			1 = For State Registrar	State of Ma	arylan		artment of F rtificate of			F	Reg. No.	006	230	01
	Physici	an	Decedent's Name (First, Middle, La	ist)						<ol><li>Date of Dea Month</li></ol>	ath Day	Year	3. Time o	f Death
	/Medic			h Anne Gri	ffin					July	5	2006	8:30	a <sup>M</sup>
	Examin	er	4a. Facility Name (If not institution, give				4b. City, Town, o				4c. 0	County of Dea		
			18 Denise Stree				Port I	Deposi				Cec		
	Funeral			Sex 7.Age 1 □ M 2 🔀 F		last birthday) Yrs.	Months Days	Hours	Min.	8. Date of Birt (Month, Day	y, Year)	9. Bir	thplace (State ountry)	or Foreign
	Director		Usuel Residence of Decedent		59				1	Nov. 27	, 19	46	Marylar	10
	land ow		10a. State 10b. County		10c. City	, Town or Lo	ocation						10d. Inside C	ity Limits
	Mary Feb	টু	Maryland Cec	il			Port	Depos	it				1 🗆 Yes	2 <b>€</b> No
	28e	rec	10e. Street and Number		1		10f. Zip Code				10g. Citiz	en of What C	ountry?	
	3a o	0	18 Denise Stree	et				21904				U.S	S.A.	
	ms 2	Funeral Directo	11. Marital Status	12. Was Decedent 8	Ever in U.	S. 13.	Was Decedent of H	lispanic Orig	in? (Spec	ify Yes or No-	. 1		erican Indian,	
9	after or ite	2	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☒ N	No		1 ⊡Yes 2 ⊠ No		, Puerto H	lican, etc.)		Black, Whi	te, etc.	
215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Id other than "naturel; or items 23a or 28e-f show short, I've Medical Exaritive must be notified at	1 by	3 ☐ Widowed 4 ☑ Divorced	If Yes, Give Year or Dates:			TEL TOS ZIZA NO	Specify:				Specify:	White	
ر د	72 h 'natu	Completed	15. Decedent's E (Specify only highest gr	ducation ade completed)		16a. Dece	dent's Usual Occup kind of work done DO NOT use retire	ation during most	of working	a		d of Business		
2	Athin ne.	ם	Elementary/Secondary (0-12)	College (1-4or 5									Publish	-
2	fled v flygie her t	ပိ	17 Fethada klama (First Middle I ass	one year	:	Admı	nistrati			nt (First, Middle,			aryland	
anc anc	be find he be find he be	Be	17. Father's Name (First, Middle, Last	" s Edward Br	cown			18. Mother		(First, Middle, Ice Lor		,		
<u>~</u>	2 should be 1 and Mental I is marked of reumatic sve	2		V4   15-11	LOWII	405 14-10	- A (1							
Maryland	12 st h and 7 ts n treun		19a. Informant's Name/Relationship	(Daughter)	١		ng Address <i>(Street</i> Linton R						21904	
	1 end 2 Health tem 27 other tre		20a. Method of Disposition	(baugitter)			sition (Name of	all Roe		ate	^	·	Town, State	
و	Pages nent of int: if it ury or o		1 ☐ Burial 2 🖾 Cremation 3 [		C	emetery, crei	natory or other pla	· 1	07/0					rrani a
Baltimore,	permit. Pages 1 end 2 should Department of Health and Men Important: if Item 27 is marke any injury or other treumatic 800.8.		' 4 ☐ Donation 5 ☐ Other (Special Service Line)	Mi-	R.		is & Co., In						, Pennsyl	.vaitta
Ba	Depa Depa Impo		Chones h.	allen	x,5	(- j	R. Name and Addre Lee A. Pa Perryvill	tterso	on & rylan	Son Fu d 2190	nera: 3-07	L Home 56	, P.A.	
	Pnysician /Medical Examiner	Iner	23a. Part1. Enter the disease, or con shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	pplications that caused y one cause on each line.  Due to (or as build b	a consequ	3CL uence of):	er the mode of dyir	ng, such as (	cardiac or	respiratory ar	rest,		Approxima Interval Be Onset and	tween
k 68760,	The law requires that the death certificate be executed the bas been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Medical Examiner	resulting in death) Last Due to (or as a consequence of):											
O. Box	that the death certific ed by the attending p detached for use as i	Physician/Medical	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	23c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Feta	death 3	Ectopic pregnanc Other (specify)	у			2:	3d. Date of de Month	*	Year
rds, P.	w requires that been signed b should be deta	by	Part II. Other significant conditions	contributing to death be	ut not resi	ulting in the u	nderlying cause giv	ven in Part I.			obacco us /es 2		to the cause of robably 4 🗶	
Vital Records,	: The law r cate has be , page 2 sh	Completed			-					24a. Was autop perfo 1 Yes		24b. Were a prior to death?	utopsy findings completion of s 2 \( \text{No} \)	available cause of
ŽĬ.	sician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hospital:			104	200		(Check only o				
	Phys this al dir	5	1 ☐ Yes 2 🔀 No 27. Mann Death	1 Inpatie			IL 3 DOA			ne 5x Resid			ecify)	
u C	ding h. Atter funer	on	1 Natural 5 Pending	28a. Date of Injui (Month, Day	y Year)	28b. Time of Injury	Wo	ryat rk? ]Yes 2.∐1		8d. Describe I	iow injury	occurred		
Division of	deat deat ctor: y the	Certification:	Accident investigate  3 Suicide 6 Could not l  4 Homicide determined	be Osa Blaca of Init	ury - At ho	ome, farm, st	reet, factory, office	1.62 5 1.		8f. Location (\$ City or Tox		Number or R	Rural Route Nur	пber,
	To the Hospital or within 24 hours after To the Funeral Direction of the Completely filled in the completely filled in the completely filled in the complete of the complete o	edical C		Physician: To the best eminer: On the basis of and manner sta	f examina									(s)
	To the Ho within 24 To the Fu completel	M	29b. Signature and title of pertifier	/./			29c. Licens	se number			29d. Plate	signed (Mon	th, Day, Year)	
			1/1an//	n			14	092		-	Ju	45 2	006	
	7		30. Name and address of person who	gompleted cause of d	Meath (Item	23a) (Type,	Print) 407	5.11	11/92	AVE	HÀ	me d	Gly in	2100%
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registra	ar's Signa	berte		, , , ,	7 "/	17.00			7 40	

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State of Maryland / Department of Health and Mental Hygiene

wary E. Omm		- For State Legistrar	ic or	iviai ylanu i		tificate o		and went	ai i iygi	Reg	No ?		2300
Physician/	1	Decedent's Name (First, Middle,		ITM					I.	ate of Death	Day Yea		Time of Death
Medical Examine		MARY LESLIE GI  4a. Facility Name (if not institution,					4b City Tow	n, or Location of I		ine 26, 20	4c. County of	of Death	1530 HIS
	ı	Route 50 and Route 19	-	oot and name of			Bowie	.,			Prince G		3
Funeral	1	5. Social Security Number 6	Sex	7. Age	e (In yrs. la	st birthday)	If Under 1			Date of Birth	(MM/DD/YYYY		place (State or
Director		579-64-4528	1 М	2 <b>X</b> F	42	Yr		Days Hours	Min.	PR 5,	1964	Foreign Cour	try) <b>D.C.</b>
á		Usual Residence of Decedent 10a State 10b. County			10c City 1	Town or Loca	tion					11	Od. Inside City Limits
р оп ан	ı	MD MONTGO	MER	Y	-	LVER S							1 XX Yes 2 No
the Maryland a or 28a-f sh tifted at once Director	3	10e. Street and Number	71111			aviik b	10f. Zip Co	de		10g	. Citizen of Wh	at Countr	y?
		1909 OWDER MII	L R	OAD				20903			USA		
3 2 2 1	5	11. Marital Status		2. Was Decedent Armed Forces?	Ever in U.S	6. 13. W	as Decedent of	of Hispanic Origin uban, Mexican, P	n? (Specify	Yes or No-	14. Race White		n Indian, Black,
	3	1 Never Married 2 Mar 3 Widowed 4 XDivor	1	Yes 2	X No		, , , , , , , , , , , , , , , , , , , ,			, 0.0.,			
ural"	2	3 Widowed 4 X Divor 15. Decedent's Education (Specif	OF	Dates:	pleted)	16a. Decede		No specify: cupation (Give kin	nd of work	done 1	Specify 6b. Kind of Bus		lustry
72 hou	3	Elementary/Secondary (0-12)	T	College (1-4 or 5		during r	nost of working	g life DO NOT us	se retired)	T			,
5-0036 ed within 72 hour tygiene. other than "natu the Medical Exa		12		4		AC	TRESS				THEA	TRE	
		17. Father's Name (First, Middle, L		•				<b>I</b>			iden Surname)		
		JAMES DONALD ( 19a. Informant's Name/Relationshi				19h Mailir	ng Address /	Street and Number			RTA WAL		'n Code)
	1	MARGARET G. BEG		•		1		W AVE.,				i, otate, z	ip dode)
Baltimore, ME permit. Pages I and 2 s permit. Pages I and 2 s Important: If iten 27 injury or other traums	-	20a. Method of Disposition				lace of Dispo rematory or o	sition (Name o	of cemetery,	Da	te :	20c. Location -	City or To	own, State
Baltimore, permit. Pages 1 a Department of He Important: If ite	1	1 Burial 2 XCremation 4 Donation 5 Other Spe	brown	Removal from Sta		=		ATION CT	TR 6/2	9/2006	STEV	ENSV	ILLE.MD
altii mit. parim iporta	1	21. Signature of Funeral Service L			10.2.2.	22.	Name and Ade	dress of Facility					
	1	JOHN R.		FRCER		1 2	$00  \text{S}_{-1}$	HARRISON	ST	ASTON.	MD 21	601	HOME PA
Physician /Medical		23a. Part I. Enter the disease, or confailure. List only one cause or			the death.	Do not enter	the mode of d	ying, such as card	diac or resp	oiratory arrest	i, shock, or hea	art	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)	_	Itiple Injuries to (or as a conse	nuence of	p						-	Death
	1	Sequentially list conditions,	b.	10 (0) 43 4 60136	queries or,								
i eu		if any, leading to immediate cause. Enter Underlying Cause		to (or as a conse	quence of)	:							
ted mist Examiner		(Disease or injury that initiated events resulting in death) Last	c. Due	to (or as a conse	quence of)	:						-	
and transi			d										
760, reate be executed physician and the burial - transit		UNPENDED	A	MENDED									
3760, ificate be g physic s the bur	- 12	F FEMALE: 3b. Was decedent pregnant in the	2	23c. If yes, outcon	ne of pregn	·	etal death	3 Ectopic p	regnancy		23d. Date of Month	delivery Da	y Year
tal Records, P.O. Box 68' rian: The law requires that the death certificate certificate has been signed by the attending ector, page 2 should be detached for use as Re Commitered by Physician	2	past 12 months?		Pregnant at	time of dea	th =	ther (Specify)		regriancy		WORT	Da	, real
Box ne death c the atten ned for us	2	1 Yes 2 No 9 V Unkn		Unknown									
P.O.		Part II. Other significant conditio	ns co	ntributing to death	but not re	sulting in the	underlying ca	use given in Part					e cause of death?
duires quires en signald be						·		<del></del>	— II,	24a. Was an			osy findings available
Records, The law require. ficate has been signage 2 should be	2								_	autopsy	p		npletion of cause of
The The ficate page	5									1 <b>✓</b> Yes 2		<b>✓</b> Yes	2 No
ician;	2	25. Was case referred to medical examiner?	Hosp	pital. 1 Innetic	- 2 I	EB/Outpotion		Other Other	heck only only only only only only only only			011	
Phys Physeral di	- 1-	1 Yes 2 No 27. Manner of Death		1 Inpatie		ER/Outpatier 28b. Time of		Injury at Work?			w injury occurre		cene
Division of Vital Records, P. spiral or Attending Physician: The law requires th hours after death. The this certificate has been signe filled in by the funeral director, page 2 should be deforted in by the funeral director, page 2 should be deformed in by the funeral director.		1 Natural 5 Pendir		Jun 26, 2006	ear)	1525 hrs	1	Yes 2 ✓ N	IDriv		ed object c		
ViSion rate de l'iter de l'inecto lin by t	2	2 Accident Investi 3 Suicide 6 Could		28e. Place of In	ury - At ho	me, farm, stre	eet, factory, off	fice building, etc.				r or Rural	Route Number, City
Div	1	4 Homicide determ		(Specify) Ma	or Road	/ Highwa	y		Rou	or Town, Statute 50 and	Route 197,	Bowie	, MD
		Condon only		To the best of m						-			
To the He within 24 To the Fu completel	5 -			n the basis of exar d manner stated	nination an	id/or investiga			irred at the				
2	=	29b. Signature and title of certifier	Vi	- Onn				cense number			29d. Date signe		, Day, Year)
		/ Cur		we		00-1		. ∪ . IVI. ⊏ .			June 27, 20		
-12-		<ol> <li>Name and address of person was Laron Locke MD. As</li> </ol>		pleted cause of d t Medical Exa			n Street, B	altimore, MD	21201				
Stat	e	31. Date filed (Month, Day, Year)	2000	32. Registra			as All w	······································		***			
Registra	ar	JUN 3 0	เทกอ	1000	الكائن موسط		The San						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 5 **Physician** brabowsk. JULY 2006 4:00PM M Nance /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 7855 AMERICANA CIRCLE #101 GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Yea Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 K Months Days Hours Min AUG 13, 54 Yrs. 1951 MARYLAND 212-56-1258 Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hygiene if Health and Mental Hygiene with a 72 in marked other than "natural", or Itama 23a or 28a-1 show other traumatic avant, The Medical Experience must be notified at Yes 2 No Directo ANNE ARUNDEL GLEN BURNIE 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number 7855 AMERICANA CIRCLE #101 21060 USA i filed within 72 hours after death v I Hygiene. other then "natural", or Itama 23s Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2X No Specify WHITE Specify: þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry during most of working Elementary/Secondary (0-12) College (1-4or 5+) ADMINISTRATIVE SECRETARY EDUCATION 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be JAMES RICHARD PATRICK, SR. PEARL A. PEREGOY 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Depertment of Health and Important: If item 27 Ian any Injury or other traun JAN GRABOWSKI/HUSBAND 7855 AMERICANA CIRCLE #101, GLEN BURNIE, MD 21060 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State SPRING HILL CEMETERY 7/10/2006 EASTON, MARYLAND 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 JOHN MERCEROO 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) encephalopathi Hepaha **Physician** 1ears /Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examine sicien and e burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical phys the 35 IE FEMALE 987 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ō Month Day Year 4 Pregnant at time of death 5 Other (specify) signed by the e P.O. I 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ Records, 2√Q No 3 Probably 4 Unknown 1 Yes should Completed Ar tery 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 25 No page 2 this certificate 2 No 1 Yes 1 Yes Division of Vital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No P 1 🗌 Yes 1 Inpatient 2 ER/Outpatient 3 DOA After the 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. М investigation the within 24 hours after deat To the Funeral Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 | Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical tha 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 0033296 my 106 , MD - 7711 Quarterfield Road, A, Glen Burnie MD 21061 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. Neil Padgett, MD

State Registrar

				partment of Health and Me	ntal Hygiene	5 23001
	Physici	an	Decedent's Name (First, Middle, Last)	2	Date of Death Month July 3, 2006	3. Time of Death
	/Medic	al	Eugene Hammer  4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	JULY 3, 2006 4c. County of D	9:40 A M
	Examin	er	Villa Rosa Nursing Home	Mitchellville	,	George's
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda) 126-20-5193 125M 2 F 83 Yrs.	y) If Under 1 Year If Under 24 Hrs. Months Days Hours Min.	Date of Birth 9. (Month, Day, Year) Way 4, 1923 W	Birthplace (State or Foreign Country) Jest Virginia
	yland		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or I	Location		10d. Inside City Limits
	8e-f st	Director	Maryland Prince George's	New Carrollton		1 X Yes 2 □ No
	with the	Dire	10e. Street and Number 6245 87th Avenue	10f. Zip Code 20784	10g. Citizen of What	USA
	ems 2	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	Was Decedent of Hispanic Origin? (Specific March 1998)     If Yes, specify Cuban, Mexican, Puerto Rice	fy Yes or No- can, etc.) 14. Race - A	American Indian, Vhite, etc.
21215-0036	within 72 hours after death with the Maryland ane. than "netural", or Items 23a or 28e-f show ta Marical Examinar must be multied at	þ	1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Married 1 Never Married 2 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Never Married 2 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married 2 Never Married 1 Never Married	1 ☐ Yes 2 🗷 No Specify:	Specify:	White
15-	in 72 h	Completed	(Specify only highest grade completed) (Giv	edent's Usual Occupation we kind of work done during most of working . DO NOT use retired)	16b. Kind of Busine	ess/Industry
	可容を	Com	Elementary/Secondary (0-12)  College (1-4or 5+) 3+	Cryptographer		remment
Maryland	ed al e	To Be	17. Father's Name (First, Middle, Last) Frank Hammer		First, Middle, Maiden Surname) e Trimboli	
Mar	and and ls m			iling Address ( <i>Str</i> ee <i>t and Number or Rural F</i> 5 87th Avenue, New C	•	
Baltimore,	jes 1 and of Health If item 27 or other tr	1 15		ematory or other place)		
Iţi.	permit. Pages I Department of H Important: If ite any injury or ot once.		'4 □Donation 5 □Other (Specify)	can's Cemetery 7/6/2 22. Name and Address of Facility Rendo		<u> </u>
Ba	Department Department Important irrupo once.		Muham Jends	9013 Annapolis Road	- 100 miles	
			23a Part1. Enter the disease, or complications that caused the death. Do not e shock, or heart failure. List only one cause on each line.	1	respiratory arrest,	Approximate Interval Between Onset and Death
	Physician /Medical	A I	Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	· Accident		
	Examiner	_	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):			
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events			
8760,	be executed sician and burial-transit		resulting in death) Last Due to (or as a consequence of):			
9	ificate by g physicas as the b	edical	d			
О. Вох	at the death certificate be executed by the attending physician and tached for use as the burial-transit	Physician/Med		B	23d. Date of Month	delivery Day Year
Ω.	es this	b	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobacco use contribut	te to the cause of death?  Probably 4 Unknown
Records,	e law requir has been si je 2 should	Completed	Demurca		authopsy prior	e autopsy findings available to completion of cause of
al R					performed? deat	h?
Vital	Physician: Th this certificate ral director, pag	To Be	25. Was ca's referred to medical examiner:  1  Yes 2 No Hospital: 1 Inpatient 2 ER/Outpati	26. Place of Death (	Check only one) = 5 ☐ Residence 6 ☐ Other (8	Specify)
n of			27. Vanner of Death 1 Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time Injury	of 28c. Injury at 28 Work?	d. Describe how injury occurred	
Division	tten deatl stor: the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm,	M 1 ☐ Yes 2 ☐ No street, factory, office 28	f. Location (Street and Number o	r Rural Route Number,
Di	i i i e	Certi	4 Homicide building, etc. (Specify)		City or Town, State)	
	the Hospitel in 24 hours a the Funeral C	Medical	29a. Certifier  (Check only one)  Certifying Physicien: To the best of my knowledge, de (Check only one)  Medicel Examiner: On the basis of examination and/or and manner stated.			
,	To the Formula Complete	Me	29b. Signature and title of continer  30. Name and address of person who completed cause of death (Item 23a) (Typ  William MUSUYC, WN YVII MILE	29c. Licence number 047603	29d. Date signed (M	fonth, Day, Year)
(	101	2	30. Name and address of person who completed cause of death (Item 23a) (Typ	e, Print)	211 Roman	40 2011
K		ate	31. Date filed (Month, Day, Year)  JUL 0 5 2006  32. Registrar's Signature	mentila per de	16 WWW 1	ne or 11t
1	Regist	rar	OUL O COOL JUSTICE DE PARTIE			

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rnest T. Hecks		State C 1- For State Registrar	of Maryland / D	epartment of C <i>ertificate of</i>		na ivientai i		g. No. 200	5 2301		
Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last)     ERNEST	т.	н	ECKSTALL		Date of Death     Month	Day Year	3. Time of Death 0415 hrs		
TOUISM. EXAMINA		4a Facility Name (if not institution, give			4b. City, Town, c	r Location of Dea	June 28, 2	4c. County of Death			
Funeral		Laurel Regional Hospital  5. Social Security Number   6. Sex	7. Age (In	yrs. last birthday)	Laurel If Under 1 Ye	ar If Under 24H	irs. 8. Date of Birtl	Prince George	holace (State or		
Director		0/0 60 0/07		61 Yrs	Months Da		in	Foreig	n NORTH untry) CAROLINA		
any		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Locat	ion				10d. Inside City Limits		
<b>*</b> .	ō	MD PRINCE GE	ORGES I	LANHAM					1 X Yes 2 No		
the Mary a or 28a- tified at	Director	10e. Street and Number 9343 ALCONA STREE	Т		10f. Zip Code 20706		10	g. Citizen of What Cour USA	ntry?		
72 hours after death with the Maryland n "natural". or items 23a or 28a-f she af Examiner must be notified at once	Funeral	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever Armed Forces?	If Y		ispanic Drigin? ( in, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,		
after de ral". or	by Fu		1 Yes 2 X f Yes, Give Year or Dates:	1	Yes 2 X N			Specify: BLA			
72 hours 1 "natural Exam		15. Decedent's Education (Specify only Elementary/Secondary (0-12)	highest grade complete College (1-4 or 5+)	during m	ost of working life	ation (Give kind o e. DO NOT use re	f work done etired)	16b. Kind of Business/I			
15-0036 filed within 72 I Hygiene ed other than t, the Medical	Completed	1 2 TH  17. Father's Name (First, Middle, Last)		SCHOOL	BUS DR		ne (First, Middle, M	GOVERNMEN	NT		
21215-0036 ould be filed within 7 Mental Hygiene marked other than ic event, the Medica	a	EARL C. HECKSTALL				ROSELLA		,			
MD 21 2 should th and Me 127 is ma umatic e	٩	19a. Informant's Name/Relationship (Type DORIS HECKSTALL/		l l	•	et and Number of ST. LANE		ber, City or Town, State 20706	Zip Code)		
Baltimore, MD 2 permit Pages I and 2 shoul Department of Health and N Important: If iten 27 is n injury or other traumaric		20a. Method of Disposition  1 X Burial 2 Cremation 3	3	20b. Place of Dispos	ition (Name of co	emetery,	Date	20c. Location - City or			
Itimo it Page riment cortant:		4 Donation 5 Other Specify: 21. Signature of Funeral Service License		RESURRECT			/03/2006				
	21. Signature of Funeral Service Licensee 22. Name and Address of Facility J.B. JENKINS FUNER 7474 LANDOVER RD., LANDOVER, MD. 20										
Physician /Medical		239. Part I. Enter the disease, or complice failure. List only one cause on each					or respiratory arre	st, shock, or heart	Approximate Interval Between Dnset and Death		
Examiner			ue to (or as a consequer		ovasculai uls		-	· <u></u>			
	iner	cause Enter Underlying Cause	ue to (or as a conseque	nce of):							
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last	ue to (or as a conseque	nce of):							
ox 68760, eath certificate be executed attending physician and for use as the burial - transit	Wedical	UNPENDED d.	AMENDED		<del></del>						
8760, itificate be ng physic as the bur		IF FEMALE: 23b, Was decedent pregnant in the past 12 months?	23c. If yes, outcome of		tal death 3	Ectopic pregi	nancy	23d. Date of delivery	ay Year		
Box 687 ce death certifice the attending p	Physician/	1 Yes 2 No 9 Unknown	Pregnant at time Unknown	of dooth	her (Specify)						
, P.O. B ires that the d signed by the	by Ph	Part II. Other significant conditions	contributing to death but	not resulting in the u	underlying cause	given in Part I.		pacco use contribute to			
cords, F aw requires nas been sign 2 should be	eted						24a. Was a		opsy findings available		
Division of Vital Records, talor Attending Physician: The law requir is after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should the fine talor.	Completed						autops perforr 1 Yes 2	ned? death?	ompletion of cause of s 2 No		
Vital Rec ysician: The his certificate director, page	Be		spital: 1 Inpatient	2 ER/Outpatient		e of Death (Chec		Residence 6 Dther			
1 of V Jing Phys After thi funeral di	n: To	1 Yes 2 No  27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of I		ury at Work?		Residence 6 Dther			
Sion Attendi r death. ector: by the fi	catio	1 V Natural 5 Pending Investigation	28e Place of Injury	- At home, farm, stree	1 1	Yes 2 No	28f Location (SI	reet and Number or Ru	ral Pouto Number City		
Division pital or Attent ours after death icral Director: filled in by the	Certification:	3 Suicide 6 Could not be determined	(Specify)		st, ractory, office	ballanig, etc.	or Town, St		ar Route Number, City		
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physicic completely filled in by the funeral director, page 2 should be detached for use as the burit	Medical (	one) 2 Medical Examiner:	n: To the best of my kno On the basis of examinat								
To wit To	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licen		T	29d. Date signed (Mor	th, Day, Year)		
		30. Name and address of person who co	impleted cause of teath	(Item 23a)	O.C	.M.E.		June 28, 2006			
CH		· ·	stant Medical Exar	miner 111 Pe	nn Street, B	altimore, MD	21201				
St Regist	ate	31. Date filed (Month, Day, Year)	2. Registrar's Si	ignature	2						

		1 - For State Registrar	State of	Marylar		artmen rtificat				lental H	ygien Reg. N	ZUL	) 6	23	006
Physicia	'n	1. Decedent's Name (First, Middle	e, Last)							2. Date of D Month	Death Da	ay	Year	3. Time	of Death
/Medic			rper							June	29	200		9:5	51 a <sup>M</sup>
Examin	er	4a. Facility Name (If not institution	-					Location o			40	c. County			
		Fort Washingt 5. Social Security Number			last birthday)	If Under		shing If Under		8 Date of B	tieth			eorge	
Funeral Director		213-40-7378 Usual Residence of Decedent	<b>X</b> M 2□ F	63	Yrs.	Months	Days	Hours	Min.	8. Date of B (Month, L Mar. 2	26, 19		D		te or Foreigr
Maryland f show	ō	10a. State 10b. County			y, Town or Lo						,		1		City Limits
the t	rect	Maryland   Princ	e George	Торр	er Mar	10f. Zip	Code	-			10a. C	itizen of W	hat Cou	ntry?	
3a or	<u>-</u>	12950 Molly Be	rrv Road			2	0772					ed S		-	
ie, Man y failu Z 12.13-0000  I and 2 should be filed within 72 hours after death with the Maryland feelalth and Mental Hygiene.  If Health and Mental Hygiene.  Other traumatic event, the Medical Examinar must be rollined at other traumatic event, the Medical Examinar must be rollined at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 ☑ Divorced	12. Was Decede Armed Force 1 XYes 2	es? □No	i		lent of His	spanic Ori n, Mexican Specify:	gin? (Spe 1, Puerto I	ecify Yes or N Rican, etc.)		14. Race	- Americ k, White,	can Indian etc.	,
bound in the last	edk	**	it's Education	35.	16a Dece	dent's Usua	I Occupa	tion	_		16b k	Kind of Bu		lack	
Z1Z15-UU36 d within 72 hours aff gione. er than "natural", or tha Medical Evani	Completed	(Specify only highe	st grade completed)		(Give	kind of wor	k done d e retired)	uring mos	t of workir	ng	100.1	and or pu	31110337111	ousny	
within iene.	E o	Elementary/Secondary (0-12)	College (1-4	or 5+)	_	enter					Pr	ivat	2		
Idryland 21212 2 should be filed within and Mental Hygiene. Is marked other than surmatic event, the Ms	d)	17. Father's Name (First, Middle,	Last)		Carp	011001		18. Mothe	r's Name	(First, Middi			*		
yland ould be f Mental 1 arked of	To B	Charles Robe	rt Harper				İ	Vio	1a	Jones					
Maryland of 2 should be file lih and Mental Hy 27 is marked oth traumatic event		19a. Informant's Name/Relations	<del>_</del>		19b. Mailir	ng Address	(Street a	nd Numbe	or Or Aura	l Route Num	ber, City	or Town, S	State, Zip	Code)	
Md 2 alth a 27 ls		Brian Nelson H	arper/ Son	n	7746	Finn	s La	ne La	ınham	, Mary	1and	207	06		
es 1 and 2 of Health a of Health a fitem 27 is		20a. Method of Disposition		20b. F	Place of Dispo	sition (Nan	ne of	.)	D	ate	20c. L	ocation -	City or To	wn, State	
Page ent o nt: If		1 🖾 Burial 2 □ Cremation  4 □ Donation 5 □ Other (S		מוש	ryland				7/7/	2006	Che	1ten	ham	Mary	1and
Dallimore, permit. Pages 1 a Department of Hec Important: If item any injury or other once.		21. Signature of Funeral Service		- 110	22 P	Name an	d Address	s of Facilit	mes,						
ate be executed xx in the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lease of Lease of Lea	C	as a conseq					-						
ath certific	Physiclan/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		h 2 ∐ Feta ntattime of d	Ideath 3	]Ectopic pro ] Other (sp						23d. Date Mon		ary Day	Year
uires that the de signed by the a	þ	Part II. Other significant condition  Dementie	-	th but not res	ulting in the u	nderlying ca	use give	n in Part I.				use contri No	bute to th 3 □ Prob		of death? □Unknown
nec he has b age 2 st	Completed			_						per	opsy formed?	pi di	rior to cor eath?	psy finding mpletion o	gs available of cause of
an: an:	ø	25. Was case referred to medica						26. Place	of Death	(Check only			∐ Yes	2 140	
Physician: this certific ral director,	To B	examiner? 1 X Yes 2 ☐ No	Hospital: 1 Inp	atient 21	ER/Outpatier	t 3 🗆 DO	A Othe	r		ne 5□Res		6 ∏Othe	r (Specif	v)	
Attending Physicien: The lav redeath.  redeath.  sctor: Attenthis certificate has	atlon: T	27. Manner of Death Natural 5 Pendir 2 Accident investi	28a. Date of (Month,	-	28b. Time of Injury		Bc. Injury Work		2	8d. Oescribe				,,	
UIVISION OT VITAI al or Attending Physicien: 1 after death. I Director: After this certificat d in by the funeral director, p	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide determ	singd 259. Place of	Injury - At he , etc. (Specif	ome, farm, str	eet, factory	, office		2	8f. Location City or To	(Street ar own, State	nd Numbe e)	r or Rura	l Route N	umber,
To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 118 Certifyir (Check only one) 2 Medical	ng Physician: To the be Examiner: On the basi and manner	is of examina	wiedge, death tion and/or in	occurred avestigation,	at the time in my opi	e, date and inion, deal	d place, a th occurre	and due to the	e cause(s e, date an	) and mar d place, a	ner as st	ated.	e(s)
To the within 2 To the complet	Me	29b. Signature and title of certifie	r_				License					te signed			)
		William T.	ane in			_ \	りくぐつ	do			Ti	144	29 -	2116	
(2)		30. Name and address of person	1000	of death (Item	LiVini	Print)	Rool	En	t 1.	مد الحادك	od no	10- 0-	mla	nd a	
Sta		31. Date filed (Month, Day, Year)	32. Red	istrar's Signa	ture .	LAINI	(-	+44	· W	Les(1 (8)	10101	, VM.IV	1111		
Registr		JUL 0 5 20	06 Beeck	istrar's Signa	freel	Q									

		State of Manuford / Deportment				
		State of Maryland / Departme	int of Health and Me ate of Death		2006	22007
		Registrar CCTTTCA		Reg. N	io. U U O	1.0001
Physic	ian	1. Decedent's Name (First, Middle, Last)	1/2 1- 1	2. Date of Death Month D	ay Year	3. Time of Death
/Medi		Lovella Elaine	Turris D	July 1	2000	14.21
Examin	ner		y, Town, or Location of Death	4	c. County of Death	+
		5. Social Security Number 6. Sex , 7. Age (In yrs. last birthday) If Und	ler 1 Year   If Under 24 Hrs.   8	3. Date of Birth	1010	lana (State or Foreign
Funeral Director		2/8-30-1697 1 M 2 D/F 7/ Yrs. Month:	s Days Hours Min.		935 Mo	lace (State or Foreign
Director		Usual Residence of Decedent	//	March 8, 1	133 100	aryland
yland Mow		10a. State 10b. County 10c. City, Town or Location			1	0d. Inside City Limits
the Maryland	to	MD Dorchester Woolfo	rd			1 ☐ Yes 2 TNo
# # # # # # # # # # # # # # # # # # #	Funeral Director	10e. Street and Number 10f. Z	Zip Code	10g. C	Citizen of What Coun	ntry?
The # 84	ai	4645 Harrisville Road	2/677		USA	
eg e	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Dec Armed Forces? 13. Was Dec	edent of Hispanic Origin? (Speci pecify Cuban, Mexican, Puerto Ri	ify Yes or No- ican, etc.)	14. Race - Americ Black, White,	
36	E.	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No If Yes, Give 1 ☐ Yes	2 No Specify:	,	Canaibu	
1215-0036 Like with the within 72 hours after deeth with the sine. Then "natural", or iteme 23s or 28s in a Medical Examinat must be multiple and the multiple of the sine of	d by	3 1 Widowed 4 □ Divorced Year or Dates:			Dia	
75 - 75	iete		vork done during most of working	7	Kind of Business/Inc	dustry
0 2 4 4	m d	Elementary/Secondary (0-12) College (1-4or 5+)	ria Worker	Car	intu Rail	of Education
other other	Be Completed	17. Father's Name (First, Middle, Last)	18. Mother's Name (			of E daca nord
Vian ould be Mental Marked	To B	Ernest Stanley	Bessie		,	
and Menite marks	F		ss (Street and Number or Rural I			Code)
01 (0 11			H. Holly Rd, Ea.			
re, M		20a. Method of Disposition 20b. Place of Disposition (N. cemetery, crematory or	lame of Dai	te 20c.	Location - City or To	wn, State
non no		1 1 1 2 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	Metery 7/8	106 11	adican	110001 100 1
Baltimore permit. Pages 1: Deportment of He important: if itea any injury or oth	H	21. Signature of Funeral Service Licensee , 22. Name	and Address Facility	2 1	raison,	Maryland
Bal permi Depe timpo any ii		Janelle C. Henry 510 M	and Address Facility RY FUNERAL HON Vashington Sti	Me, F. A.	~ 2 MD.	21612
		23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mo	ode of dying, such as cardiac or	respiratory arrest,	39,0101	Approximate
A Property		shock, or heart failure. List only one cause on each line.  Immediate Cause (Final	41/110=			Interval Between Onset and Death
Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. ACUTE RENAL From Due to (or as a consequence of):  VENTRICULAR TAKE	AILUKE			
Examiner		VENTRICULAR TAI	CHYCARIA			
	je	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury				
outed ansit	Examiner	Cause (Disease or injury that initiated events c.				
760, le be executed sicien and e burial-transit		resulting in death) Last Due to (or as a consequence of):				
1- 0 20	cai	d				
Box 68° leath certificat attending phy	Jed	IF FEMALE:		1		
SOX Three	an/	23b. Was decedent pregnant 23c. If yes, outcome of pregnancy	pregnancy		23d. Date of delive	,
O. E. B. dea	Sici	1 Yes 2 No 4 Pregnant at time of death 5 Other (s			Month	Day Year
p.O. that the ded by the detached	Phy	9 Unknown				
IS, F res tha signed be de	Ď	Part II. Other significant conditions contributing to death but not resulting in the underlying			use contribute to th	ably 4 Unknown
Division of Vital Records, P.O. Box 68 to attending Physician: The law requires that the death certifical elector. After this certificate hes been signed by the attending phinin by the funeral director, page 2 should be detached for use as the control of the co	Completed by Physician/Med	WREAD OBESITY  CHRONIC RESPIRATORY FAILURE  DEPRESSION	-	1 Tes	ZENO 3 Proba	abiy 4 Unknown
lec staw les b	pe	CHICONIE PENTINATORY PARLURA		24a. Was an autopsy	24b. Were autor prior to cor	psy findings available npletion of cause of
The It	ပ်	DEPRESSION		performed? 1□ Yes 2☑N	death? lo 1 ☐ Yes	2 No
f Vita ysician: is certific director,	Be	25. Was case referred to medical examiner?	26. Place of Death	Check only one)		
Of Of Phys.	2	1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ EP/Outpatient 3 ☐ ☐ 27. Manney of Death 28a. Date of Injury 28b. Time of			6 ☐Other (Specify	<i>'</i> )
Sing After funer	<u>6</u>		28c. Injury at Work? 1	ld. Describe how inj	ury occurred	
isio ittendi death ctor: A	cat	3 Suicide 6 Could not be		of Location (Street	and Number or Rura	I Pouto Numbos
Division o  To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification: To	4 Homicide determined building, etc. (Specify)	Ty, Office	City or Town, Sta	te)	noute (vanice),
Di To the Hospital or within 24 hours afte To the Funeral Dir		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre	d at the time, date and place, an	d due to the cause(	s) and manner as st	ated
24 h Fur	Medicai	(Check only 2 Medical Examiner: On the basis of examination and/or investigation one)	n, in my opinion, death occurred	at the time, date an	nd place, and due to	the cause(s)
To the within 2 To the complet	Me	29b. Signature and title of certifier 2	9c. License number	29d. D	ate signed (Month, L	Day, Year)
		by Bolis	D0059487	6	17/01/2	006
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			1-1-	
			Easton, MD 214	501		
	ate	at a second and a second a second and a second a second and a second a second and a		<b>V</b>		
Regist	rar	JUL 0 6 2006				

			For State Registrar	State o	f Mary	land / Der Ce	artmen ertificat	t of H e of I	lealth a	and M		giene	06	230	)08
П	Physici	an	1. Decedent's Name (First, Middle, I Elisabeth A. Han								2. Date of Dea Month	Day	Year	3. Time of	Death A M
	/Medic Examin		4a. Fecility Name (If not institution, g		mber)		4b. City,	Town, or	Location	of Death	July	5 4c. Coun	2006 ty of Death	1:05	
			956 Nelson Place		* A (I-	- Land Blade de	) If Under		nold	24 Hrs	G D-1- (D)		ne Aru		
ľ	Funeral Director		475-38-3590	Sex 1 ☐ M 2XX F		6 Yrs.	Months	Days	Hours	Min.	8. Date of Birth (Month, Day July 12	, Year)	9. Birthp Coun Au	lace (State o try) stria	r Foreign
	yland		Usual Residence of Decedent  10a, State 10b, County		10	c. City, Town or	Location						11	0d. Inside Cit	ty Limits
	Ba-f et	ector	Virginia Fair	fax		- · · · · · · · · · · · · · · · · · · ·			Resto	n	<del></del>			1 Tyes	2 <b>X</b> No
	th with th	al Dire	10e. Street and Number 11546 Links Driv	<i>r</i> e			10f. Zip		20190	)		10g. Citizen of	What Coun J.S.A.	try?	
036	permit. Pages 1 and 2 should be iiled within 72 hours after death with the Maryland Depertment of Heelih and Mental Hygiene. Importent: If Item 27 is marked other than "natural", or Items 23a or 28s-f show eny injury or other traumatic event, Its Maralcal Examical must be notified at Once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ☒ Divorced	12. Was Dec Armed Fo 1 Tes If Yes, Gi Year or D	irces? <b>2€</b> XNo ve	r in U.S. 13	Was Deced If Yes, spec 1 Yes		ispanic Ori in, Mexicar Specify:		ecify Yes or No- Rican, etc.)	14. Ra Bl Spec	ace - Americ ack, White, o ify: Wh		
Maryland 21215-0036	within 72 ho ene. than "natur	Completed by	15. Decedent's (Specify only highest ( Elementary/Secondary (0-12)	Education trade completed) College (	1-4or 5+)	(Gin	edent's Usua re kind of wo DO NOT us ecreta	rk done d se retired	ation during mos	it of worki	ing	16b. Kind of	Business/ind	,	
land 2	uld be filed Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, La Maximilian Sted	st)				-			e (First, Middle, le Anto	Maiden Suma		.,,	-
, Mary	and 2 sho		19a. Informant's Name/Relationship Alec Harper/sor				Nelse				al Route Numbe nold, Ma				1
Baltimore,	Pages 1 ment of He lent: If Iten jury or oth		20a. Method of Disposition  1 ☐ Burial 2 ☑ Cremation 3  4 ☐ Donation 5 ☐ Other (Special Control of	city)	State ]	20b. Place of Dis cemetery, cr Baltimor	e Crei	nato	- [	7/7/:	1	20c. Location Baltin	ore, l	Maryla	
Ball	Departition Departition Important Im		21. Signature of Fundral Pervice Lic	· ful	Ue.	1 ر	47 Dul	ke o	f Glo	uces	hn M. Ta ter St.	Annapo	unera olis,	MD 21	401
	Pnysician		23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	ly one cause on o	each line.	ancer	nter the mod	le of dyin	g, such as	cardiac	or respiratory ari	rest,		Approximate Interval Bets Onset and D	ween Death
	/Medical Examiner				(or as a co	onsequence of):									
	uted d ansit	Examiner	Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to	or as a co	ons-quence of:									
68760,	ate be executed hysicien and he burial-transit	Cal	resulting in death) Last	Due to	(or as a co	onsequence of);									
P.O. Box 68	thet the death certifical hed by the ettending phy detached for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown		ointh 2 🗀 nant at time	Fetal death 3	□Ectopic pr						ate of delive	,	⁄ear
	The law requires thet the site has been signed by the bage 2 should be detache	ρ	Part II. Other significant conditions	contributing to d	eath but no	ot resulting in the	underlying o	ause give	en in Part I			bacco use col		e cause of d	
Il Records,		Completed									24a. Was a autop: perfor 1 Yes			osy findings a npletion of ca 2 No	
Vita	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:		0[] [P/O:	25.00	Oth	0.5		Check only or			dence	
Division of Vital	fe en	tion: To	27. Manner of Death 1 ☒ Natural 5 ☐ Pending 2 ☐ Accident investigat	28a. Date (Mon	_	2 ER/Outpati 28b. Time par) Injury		8c. Injun Worl	4 🗆 190		me 5 Resid 28d. Describe h			"	
Divis	s efter des s efter des al Director ad in by th	Certification;	3 Suicide 6 Could not determine	d 288. Place	of Injury - ing, etc. (S	At home, farm, :	street, factory	, office			28f. Location (S City or Tow	treet and Nun n, State)	iber or Rura	Route Num	ber,
	To the Hospital or Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fu	edicai	29a. Certifier the Check only one) 1 Check only 2 Medical Ex	Physician: To the aminer: On the band man	a best of m asis of exa ner stated	amination and/or	ath occurred investigation	at the tin , in my o	ne, date an pinion, de <i>a</i>	nd place, ath occurr	ed at the time, o	late and place	, and due to	the cause(s)	)
)	To Too	×	29b. Signature anaptitle of celtifier	· Wat	h		290		3118		14	9d. Date sign July	ed (Month, L 5, 200		
			30. Name and address of person who Dr. Stanley Wat	kins 90	0 Bes	stgate R	oad,#	300	Anna	apoli	s, Mary	land	21401		
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 0 6	2006	legistrar's	Signature	all of							- 1 - 1 - 1	

			1 - For State Registrar	State of M	aryland / De		of Health			ene No. 006	23009
			Decedent's Name (First, Middle, La	est)					. Date of Death		3. Time of Death
	Physici /Medio		George Emory	Hall					July 03	3 2006	2000 M
	Examin		4a. Facility Name (If not institution, given				own, or Location			4c. County of Death	
			Carroll Hospita				estminst	I		Carro	
	Funeral Director		122-20-3513	Sex 7. Ag	ge (In yrs. last birthd 80 Yrs	Months	Year If Under Days Hours	Min.	Date of Birth (Month, Day, Y July 12	9. Birth Cou	place (State or Foreign ntry) W.VA
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town o	r Location					10d. Inside City Limits
	Maryl -1 sho fled a	tor	MD Car	roll	V	<i>l</i> estmins	ter				1 ☐ Yes 2 ☐ No
	h the	Director	10e. Street and Number		<del></del>	10f. Zip C	Code		10g	. Citizen of What Cou	ntry?
	th wit	alp	324 Royer Road				21158			USA	
_	r dea	Funeral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.	3. Was Deceder	nt of Hispanic Or y Cuban, Mexica	igin? (Speci	fy Yes or No- can, etc.)	14. Race - Ameri Black, White	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. is marked other than "natural", or items 23a or 28e-f show aumatic event, the Mantal Examiner must be notified a	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced	1 Taryes 2 ☐ If Yes, Give Year or Dates:	No WWII	1 ☐ Yes 2 【				Specify:	White
00-	2 hou	ted	15. Decedent's E	ducation	16a. De	cedent's Usual	Occupation		16	b. Kind of Business/Ir	dustry
218	thin 7 e.	Completed	(Specify only highest gr Elementary/Secondary (0-12)	College (1-4or	lit	e. DO NOT use	done during mos retired)	st of working			
21	filed wi Hygien other th ent, the		12			Bus Dr				Greyhou	nd
_	d be fi	Be C	17. Father's Name (First, Middle, Last George Emory Ha						First, Middle, Mai Trimble	,	
کر	should ind Men i marke umatic	2	19a. Informant's Name/Relationship		19b. M	ailing Address (S				ity or Town, State, Zij	Code)
ž.	ロモアキ		Ruth Hall/wife						inster,		,
ore	yes 1 and 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐	Removal from State		crematory or oth	er place)	Dat		c. Location - City or T	
ב ב	t. Pages rtment of rtant: If It njury or o		`4 □Donation 5 □ Other (Speci	(y)	St. Mat		emetery			Richmond,	VA
Ba	permit. Pages 1 an Department of Heal Important: if Item 2 any injury or other once.		21. Signature of Funeral Service Lice	1588						pel, P.A. nster, MD	21157
			23a. Party. Enter the disease, or com shock, or heart failure. List only	plications that caused one cause in each li	the death. Do not ne.	enter the mode	of dying, such as	cardiac or r	espiratory arrest		Approximate tnterval Between
F	hysician		Immediate Cause (Final disease or condition resulting in death)	a. (0)	ronary.	Acte	4 1)13	001-	e	4	Onset and Death
E	/Medical Examiner		Tooling in dealing	1).	a consequence of):	, ,	/			X	2
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as	a consequence of):	~		·			45
	cuted nd ransit	Examiner	that initiated events	c							
8760,	death certilicate be executed e attending physician and ed for use as the burial-transit		resulting in death) Last	Due to (or as	a consequence of):						
687	ficate physics the	edical	•	d							
Rox	leath certific attending p	M/U	tF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome		3 ⊟Ectopic preg				23d. Date of delive	ery
n O	at the deat by the att tached for	Physiclan/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant a 9☐Unknown		5 Other (spec		-		Month	Day Year
J.	mat in ed by detac		Part II. Other significant conditions	contributing to death b	ut not resulting in th	e underlving cau	se given in Part I		23e. Did tobac	co use contribute to t	he cause of death?
Vital Records,	requires that the been signed by th hould be detache	d by				, , ,			1 ☐ Yes	***	pably 4 □Unknown
OS S		ompleted							24a. Was an	24b. Were auto	psy findings available
ř	une taw cate has b page 2 st	Com						57	autopsy performed	death?	mpletion of cause of 2□ No
<u>=</u>	rnysician: In this certificate rat director, pag	Be	25. Was case referred to medicat examiner?				26. Place	of Death (C	Check only one)		
5	this craft dire	၉	1 ☐ Yes 2 No	Hospital: Inpatie		tient 3 DOA				e 6 □Other (Specif	y)
<u> </u>	After After funera	tlon:	27. Manner of Delath  1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigatio	28a. Date of Inju (Month, Da	y Year) 28b. Time Injus	e of 28c y M	lnjury at Work? 1 ☐ Yes 2 ☐		d. Describe how i	njury occurred	
DIVISION	el or Attending s after death. I Director: After d in by the fune	ifica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of tnj	ury - At home, farm,					t and Number or Rura	ul Route Number,
= :	s after s after el Dire	Certification:	4  Homicide determined	building, et	c. (Specify)				City or Town, S	itate)	
	To the Hospitel or Attending I within 24 hours after death.  To the Funerel Director: After completely filled in by the funer	edical	29a. Certifier (Check only one)  Certifying Pt 2 Medical Exer	nysicien: To the best niner: On the basis o and manner st	f examination and/or	eath occurred at r investigation, in	the time, date an my opinion, dea	d place, and th occurred	due to the caus at the time, date	e(s) and manner as s and place, and due to	tated. the cause(s)
	vithin 24 I	Me	29b. Signature and title of cartifier			29c. L	icense number		29d.	Date signed (Month,	Day, Year)
١	161		· Will I	16 A	10	D	20581	37		7/5/06	>
	IZTIVA		30. Name and address of person who	795 Sto	no Aut	st 30	7 (	estini	nstel	MD ZII	57
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr	ar's Signature	hand			110		
	negistr	aı	JUL 0 5	7000	we so	March					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1 Decedent's Name (First Middle Last 2. Date of Death 3 Time of Death Month Day Year **Physician** Pearl Winifred Handler 1:45 p M 07 02 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Lutheran Village Westminster Carroll If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 6. Sex **Funeral** Days Months 1 □ M 2 💢 F Director 83 08-29-1922 218-12-742<u>7</u> Usual Residence of Decedent filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other than "naturel", or items 23s or 28s-4 show other traumatic event, it a Machel Examinar must be notified at MD 1 ☐ Yes 2 ☑ No Carroll Hampstead Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3980 Rustin Drive 21074 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2√2 No Specify: Specify: Completed by White 3 ₩ Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Secretary Manufacturing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) rmit, Pages 1 and 2 should be file spartment of Health and Mental Hi portant: If item 27 is marked oth y injury or other traumatic even Be Earl Perry Grose ပ Annie Cross 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3980 Rustin Drive, Hampstead, MD 21074 Kimberly L. Wilhelm - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2XI Cremation 3 ☐ Removal from State permit, Page Department of Important: If any injury or \* 4 □ Donation 5 □ Other (Specify) Carroll Cremation 07-05-06 Hampstead, MD 22. Name and Address of Facility Eline Funeral Home 21. Signarue of Funeral Service Licens MOO550 934 South Main St., Hampstead, MD 21074 roland 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause op each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician ronary /Medical to (or as a consequence Due Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examiner The law requires that the death certificate be executed burial-transit ed by the attending physician and detached for use as the burial-tran Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 1 ☐ Yes 2 No 4 Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 □ Unknown been signed by 23e. Did tobacco use contribute to the cause of death? Completed by should be 2100 1 ☐ Yes 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 has autopsy perform certificate 1 🗌 Yes 1 Yes 25. Was case examiner? completely filled in by the funeral director. Be referred to medical 26. Place of Death (Check only one, 2 No Hospital: 1 | Inpatient Other: 4 Nursing Home Certification: To 1 🗌 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 Other (Specify) this Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Director: After or Attending Natural Accident 5 Pending investigation 2 No death. 1 Yes 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital within 24 hours a 1 Lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifi-WIL ne and address of person who completed cause of death (Item 23a) (Type, Print) 4 ER 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

			1 - For State Registrar	State of Maryla	Ce	rtificate of	Death	F	Reg. No.	
	Physici /Medic		Decedent's Name (First, Middle, La Nancy Virgina		Y VIRGI	NIA HINTO	)N	2. Date of Dea Month June 30	Day	Year 3. Time of Death 07:43AM
}	Examir		4a. Facility Name (If not institution, giv Carroll Hosp	ital Center		Westm	r Location of Deat			roll
	Funeral Director		5. Social Security Number 6. S 382-36-0465  Usual Residence of Decedent	5ex 7. Age (In yi	rs. last birthday Yrs.	Months Days	If Under 24 Hrs Hours Min.	8. Date of Birt (Month, Day June	1924	9. Birthplace (State or Foreign Country) Reisterstown, M
	death with the Maryland ms 23a or 28a-f show	ctor	10a. State 10b. County MD Balti		City, Town or L Reiste					10d. Inside City Limits 1 🗗 ves 2 🗆 No
	h with th	al Director	10e. Street and Number  24 Bond Ave.			10f. Zip Code 2113	6		10g. Citizen of V USA	Vhat Country?
036	be filed within 72 hours after death with the Marylan lat Hygiene. d other than "natural", or items 23a or 28a-1 show event, the Medical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 22 No If Yes, Give Year or Dates:	U.S. 13.	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☐ No	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Rac Blac Specify	e - American Indian, ck, White, etc. Bla <b>c</b> k
9500-6121	filed within 72 hours after Hygiene. ther than "natural, or ite int, the Medical Examine	Completed	15. Decedent's E (Specify only highest gra Elementary/Secondary (0-12)		(Giv	edent's Usual Occup e kind of work done DO NOT use retired Lal Worke:	during most of wo d)	rking	16b. Kind of Bu	usiness/Industry
Maryland 2		To Be Co	17. Father's Name (First, Middle, Last, Murray Welch			ICI WOLKE	18. Mother's Na	me (First, Middle, n Little		
Mar	s 1 and 2 should I Health and Men item 27 is marke other traumatic		19a. tnformant's Name/Relationship ( Rev. Dr. James E.			ing Address <i>(Street</i> 24 Bond A				
Baltimore,	permit. Pages 1 and. Department of Health Important: if item 27 any injury or other tr QDC&.		20a. Method of Disposition  1 Surial 2 Cremation 3 4 Donation 5 Other (Specific	Removal from State (fy)	cemetery, cre Carrison	osition (Name of ematory or other place n Forest	vet.Cem.	7/2006	Owings	City or Town, State Mills, MD
Balt	permit. Departr imports any inj		21. Signature of Emeral Service Lice	nsee .	2	2 Name and Addre	ss of Facility 4.	ız wasnı		d., Westminster, MD 21157
	Physician /Medical Examiner		23 Part : Ehler the disease, or com sock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to for as a cons	him	Palumon  The Mc	ng, such as cardia	c or respiratory ar	rest,	Approximate thierval Between Onset and Death
8/60,	death certificate be executed e attending physicien end of for use as the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underfying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as a cons	,					,
O. Box 68		Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⋈ No 9 □ Unknown	23c. If yes, outcome of predictions of predictions of the control	etal death 3	□Ectopic pregnance	у		23d. Dat Mo	te of delivery nnth Day Year
7	The law requires that the deite has been signed by the a bage 2 should be detached to	þ	Part II. Other significant conditions of Dishells Mills	contributing to death but not in	resulting in the	underlying cause giv	ven in Part I.	23e. Did to	-	ribute to the cause of death?  3 Probably 4 Unknown
II Kecords,		Completed	- Haph Mission	, , , , , , , , , , , , , , , , , , ,				24a. Was autop perfor 1 🗌 Yes	rmed?	Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 □ No
Vital	Physician: rthis certifica ral director, p	To Be	25. Was case referred to medical examiner?	Hospital: 1 Inpatient 2	☐ ER/Outpatie	ent 3 DOA Oth	100	ath <i>(Check only o</i> Home 5 ☐ Resid		er (Specify)
ion of	<u>a</u> = <u>a</u>		27. Manner of Death  1 Natural 5 Pending 2 Accident investigatio	28a. Date of Injury (Month, Day Year,		of 28c. tnjur			now intury occurr	
Division	To the Hospital or Attending Phwithin 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be determined		t home, farm, s ecify)	treet, factory, office		28f. Location (S City or Tow	Street and Numb vn, State)	er or Rural Route Number,
	ne Hospi n 24 hou ne Funer sletely fill	edical	29a. Certifier 1 Certifying Pl (Check only 2 Medical Example)	hysician: To the best of my iminer: On the basis of exam and manner stated.	knowledge, dea ination and/or i	th occurred at the til nvestigation, in my o	me, date and place opinion, death occ	e, and due to the durred at the time, of	cause(s) and ma date and place,	inner as stated. and due to the cause(s)
	within 2 To the	Me	29b. Signature and title of certifier	1 mo		29c. Licens	3 84	1		d (Month, Day, Year)
-	WH S		30. Name and address of person who	completed cause of death (t		purint)	Int 1	Dahe F	UBHRIV	un, MD 21136
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sig		South			- 1 21	

			FOI	artment of Health and Mental Hygiene rtificate of Death	012
*	Physici /Medic		1. Decedent's Name (First, Middle, Last)  Jaunita Barnett Hansen	2. Date of Death Month Day Year July 5, 2006 0156	of Death
	Examir		4a. Facility Name (If not institution, give street and number) Carroll Hospital Center	4b. City, Town, or Location of Death Westminster  4c. County of Death Carroll	
At .	Funeral Director		5. Social Security Number 216-60-7876  6. Sex 1 □ M 2 ☑ F  7. Age (In yrs. last birthday) Yrs.	If Under 1 Year   If Under 24 Hrs.   8. Date of Birth   9. Birthplace (State (Month, Day, Year)   7.   1952   Maryland	or Foreign
	aryland •how	J.	Usual Residence of Decedent  10a. State  10b. County  Maryland  Carroll  10c. City, Town or Lo	Tital and an artist and	City Limits
	death with the Maryland me 23a or 28a-f ehow count be notified at	Directo	10e. Street and Number  117 West Main Street, apt B	10f. Zip Code 10g. Citizen of What Country?  21157 USA	
30	or its	by Funerai	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 □ Never Married 2 □ Married  1 □ Yes 2 □ No	Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)  1□ Yes ※ No Specify:  Specify: white	
1215-0036	within 72 he ene. then "natu	Completed t	15. Decedent's Education (Specify only highest grade completed) 16a. Dece (Give	dent's Usual Occupation  I kind of work done during most of working  DO NOT use retired)  Seamstress  Sewing Factory	
andz	be filed tal Hyg d othe event,	To Be Co	17. Father's Name (First, Middle, Last) Harley Barnett	18. Mother's Name (First, Middle, Maiden Sumame)  June Wilma Stultz	
Mary	d 2 shouth and N 7 is man	1		ng Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sara Lane, Hanover, PA 17331	
more,	Pages 1 and nent of Healt int: If item 2 iry or other		Durial 24+  Cremation 3	osition (Name of matory or other place)  07/10/ roll Crematory 2006  Date 20c. Location - City or Town, State Winfield, MD	
Baitimor	permit. Page Depertment of Important: If any Injury or oper.		TOTION .	2. Name and Address of Facility Myers—Durboraw Funeral H 91 Willis Street, Westminster, MD 21157	ome
I	Physician		23a. Pan 1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.		etween
8/00,	the death certificate be executed by the ettending physician and transit transit transit.	dicai Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  C.  Due to (or as a consequence of):		
O. BOX 6	that the death certificate be exected by the ettending physician detached for use as the buria	Physician/Me		□Ectopic pregnancy 23d. Date of delivery Month Day	Year
Hecords, P.	The law requires that he has been signed by hage 2 should be deta	2	Part II. Other significant conditions contributing to death but not resulting in the under the support of the s	differe 1 Yes 2 No 3 Probably 4)	Unknown
_		Completed		24a. Was an autopsy finding prior to completion of death?  Yes 2 \( \subseteq \) No 1 Yes 2 \( \subseteq \) No	s available cause of
Vital	ysician; is certific director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 No  Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatien	26. Place of Death (Check only one)  1. Other: 4 \( \) Nursing Home 5 \( \) Residence 6 \( \) Other (Specify)	
lon or			27. Manner of Death 1 Natural 5 Pending (Month, Day Year) 2 Accident investigation		
DIVISION	s after des	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, str building, etc. (Specify)	reet, factory, office 28f. Location (Street and Number or Rural Route Nu City or Town, State)	ımber,
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, deatled the control of the control of the control of the certifier of the	h occurred at the time, date and place, and due to the cause(s) and manner as stated.  Exercise the cause of	)(s)
	P S S S S S S S S S S S S S S S S S S S	Σ	29b. Signature and the of certifier	29c. License number 29d. Date signed (Month, Day, Year)  Tuly 5, 200	16
1	2		30. Name and address of person who completed cause of death (Item 23a) (Type, Enrico A. Grangeruso, Mb	· A 1 / /	157
1000	Sta Registi		31. Date filed (Month, Day, Year)  32. legistrar's Signature	andie	

			For State		or Print in B of Maryland	d / Depa		of H	ealth and	-	łygien	e 2 n	ble.	2301
	Physici /Medic		1. Decedent's Name (First, Middi  DONALD NEWN		R	Ce	runcate	OIL	Jean	2. Date of Month		ay	Yeer 006	3. Time of Death 8:50AM M
	Examin		4a. Facility Name (If not institutio 501 DUTCHMAN	IS LANE,	APT #301			STO	Location of De  N  If Under 24 F			c. County	TALI	ВОТ
	Funeral Director		5. Social Security Number 535-42-6875 Usuel Residence of Decedent	6. Sex 1 <b>X</b> M 2□	7. Age (In yrs. In 103	Yrs.		Days		frs. 8. Date of (Month, MAR 2	Day, Year	903	Cou	place (State or Foreign intry) RYLAND
	a-f show	Director	MD TA	LBOT	10c. City	r, Town or Lo	STON							10d. Inside City Limits 1 XYes 2 No
	th th	Oire	10e. Street and Number				10f. Zip C	ode			10g. C	itizen of V	What Cou	Intry?
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Item 27 is marked other then "natural", or items 23s or 28s-f show other traumatic event, the Medical Examinational Depropries and Other traumatic event, the Medical Examinations of the Confilled at	by Funeral	501 DUTCHMANS  11. Marital Status  1 Never Married 2 Mar  3 Xidowed 4 Divorced	12. Was [ Armed 1 ☐ Y If Yes	SPT. #301 Decedent Ever in U.: 1 Forces? es 2 Xio , Give or Dates:		Was Decede	y Cuba	spanic Origin?	(Specify Yes or lerto Rican, etc.)	No-		ck, White	ican Indian,
21215-0	within 72 ho ene. thsn "netur tre Medical	Completed	(Specify only higher Elementary/Secondary (0-12)	Colleg	ge (1-4or 5+)	(Give life.	DO NOT use	done o	turing most of	working		Kind of B		endustry  VERNMENT
2	filed v Hygie other t		12 17. Father's Name (First, Middle,		+	ENG	INEER		18 Mother's I	Name (First, Mid				
Maryland	2 should be filed withir and Mental Hygiene. is marked other then aumatic event, the M	To Be	FREDERICK HARE  19a. Informant's Name/Relation.	PER		10h Maili	na Address (	Street	FLORI	ENCE NEW	NAM			in Code)
Ma	d 2 sl th an 7 is r traur		MARILYN GINTE							PT.23, S				
	Pages 1 and 2 nent of Health int; if Item 27 iry or other tru		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation	3 □Removal fr	om State	lace of Dispo emetery, cre	osition (Name matory or oth	of er plac	θ)	Date	20c.	Location -	City or T	own, State
Baltimore,	permit. Pages 1 and 2 Depertment of Health a Important; if item 27 it any injury or other tra once.		21. Signature of Funeral Service	Licensee	. CF.SA	ř	ELLOWS	Addres	ELFENBE	7/10/20 EIN & NE ST EASTO	WNAM	FUNE	RAL	HOME PA
1760,	Physician was proposed at proposed and propo	ical Examiner	23a. Part1. Enter the disease, o shock, or heart lailure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due	at caused the death on each line.  To (or as a consequence to (or as a consequ	uence of):	re			Sta A				Approximate Interval Between Onset and Death
P.O. Box 687	requires that the death certificate be executed een signed by the ettending physicien end hould be detached for use as the burial-transit	ysician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	1 □ L 4 □ P	, outcome of pregna ive birth 2 ☐ Fetal regnant at time of de inknown	death 3	□Ectopic pre □ Other (spe						te of deliventh	very Day Year
	> 4 5	Completed by Physician/Medical	Part II. Other significant condit Hypertensio Hotery Dis	ions contributing  O, HOC  SCASC,	to death but not resu The STO Hupper CI	ulting in the u	inderlying cal	LOV Len	en in Part I.  ONA CO	24a. W	Yes  Vas an utopsy erformed?	2 💢 o	3 Pro	the cause of death?  bably 4 □Unknowr  opsy lindings available  ompletion of cause of  2 □ No
/ita	cian; ertific	Be	25. Was case referred to medic examiner?					011		Death (Check or	піу опе)			
Division of Vital Records,	To the Hospital or Attending Physician. The law within 24 hours effer death.  To the Funeral Director: Affer this cartificate has completely filled in by the funeral director, page 2	Certification: To	3 ☐ Suicide 6 ☐ Could	28a. D	I Inpatient 2 Date of Injury Month, Day Year)  Place of Injury - At houlding, etc. (Specify	28b. Time of Injury	of 28	c. Injun Work	4   Nutsin	28d. Descri		jury occur	red	ify) ral Route Number,
	he Hospitu in 24 hours he Funera pletely filler	edical		I Examiner: On t	o the best of my kno he basis of examina manner stated.						ne, date a	nd place,	and due	to the cause(s)
)	To ti withi To ti	W	29b. Signature and title of certific	n a. 7	Elyana	1 m			e number	)	29d. D	ate signe	/_	. Day, Year)
	(2)		30. Name and address of person	who completed	cause of death (Item	1 23a) (Type	, Print)							

State

Registrar

Jennifer Hollywood, 538 Cynwood Drive, Easton, MD 21601
31. Date liled (Month, Day, Year) 32. Regular's Signature

JUL 1 1 2006

JUL 1 1 2005

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [] [] [5] 1 - For State Registrat Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death HUSTON Month **Physician** ELORES ouise *0923* <sup>M</sup> Suly /Medical 4b. City, Town, or Location of Death Fecility Name (If not institution, give street and number) 4c. County of Death Examiner legional medical Center If Under 1 Year If Under 24 Hrs. NICOMICO 8. Date of Birth (Month, Day, Year) April 8, 19 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 226-26-0960 Days Hours 1 M 2 SF Director Usual Residence of Decedent 10a. State 10c Gity. Town or Location 10d. Inside City Limits r then "natural", or iteme 23a or 28a-f ehow the Medical Examinar must be notified at OCO MOKE MD WORCESTER 1 No 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country ark U.S.A 010 21851 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Tes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Black Maryland 21215-0036 1 ☐ Yes 2 No δ Specify: 3 ☐ Widowed 4 X Divorced permit. Pages 1 and 2 should be filed within 72 hours Department of Heelth and Mental Hygiene. Important: If item 27 le marked other then "natural; eny Injury or other traumatic event, it e Medical Exa Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) SECrEtary lyr. Treen 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Haymond -ollick 19a. Informant's Name/Balationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Roberts / Daughter 45 Alberge Ln Middle IWanna Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City o Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Pocomoke, Johnson Meck Cemeters 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Anthony E. Ward Funeral Home 21. Signature of Funeral Service Licensee 30639 Hampden Are 40 21853 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Immediate Cause (Final disease or condition resulting in death) Onset and Death Physician D.H C.1.2. 1 month /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner ed by the attending physician end detached for use as the burial-transit death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death
4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 5 Other (specify) P.O. 1 Yes 2 No sete has been signed by page 2 should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? this certificete has autopsy performed 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 Yes 2 No 1/ Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: within 24 hours effer death.

To the Funeral Director: After completely filled in by the funer. 1 Natural 5 Pending 1 Yes 2 No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29b. Signature and title of pertifier 29c. License number 29d. Date signed (Month, Day, Year) D54879 July 8, 2006 and address of person who completed cause of death (Item 23a) (Type, Print) 100 E. CARROLL St. SALISbury Md 21801 M. TREUTH MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

			For State			nd / Depa		t of H	ealth ar		ental Hygi	ene 2 A	0.6	231	115
			Registrar  1. Decedent's Name (First, Middle, L	ast)		Cei	lincall	e or L	Jeani	2	Reg	J. No U		3. Time of De	eath
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	death with the Maryland me 23a or 28a-f ehow roust be notified at	Funeral	11. Marital Status		edent Ever in l	J.S. 13.				in? (Speci	fy Yes or No- can, etc.)	14. Race		n Indian,	
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Maryland 21215-0036	0 5 5 0	o Be	Benjamin Harriso		le					,	Elizab				
<u></u>	should be and Menta a marked umatic ev	ᅀ	19a. Informant's Name/Relationship			19b. Mailir	ng Address	(Street a			Route Number,			Code)	
Š	s 1 and 2 shoul if Health and Me Item 27 is mark other traumati		Norman Edward Br	amble	(Son)	373	Havei	for	d Ave.	We	nonah,	NJ 080	90		
Baltimore,	of Hez		20a. Method of Disposition			Place of Dispo	sition (Nan	ne of ther place	9)	Dat	te 20	Oc. Location - C	ity or Tow	n, State	
Ĕ			1 25 Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Special Control of Contr		State St.	. Steph	ens C	emet	ery of	7-11-	-2006 D	elmar,	Dela	ware	
a	permit. Pag Department Important: eny Injury o		21. Signature of Funeral Service Lic	ensee		27	Name an	d Addres	s of Facility	m <sub>O</sub>					
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	/Medical Examiner		resulting in death)		-										27
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89	The law requires that the death certifica ste hes been signed by the attending ph page 2 should be detached for use es th	Med	IF FEMALE:												
P.O. Box	ath ce ttendi or use	lan/l	23b. Was decedent pregnant in the past 12 months?	1 Live	itcome of pregr birth 2 ☐ Fet	al death 3[	Ectopic pr					23d. Date Mont		y Day Yea	ar
0	the a	by Physician/Med	1 ☐ Yes 2 D No 9 ☐ Unknown	4□Preg 9□Unkr	nant at time of nown	death 5	Other (sp.	ecify)				, work		4)	
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ö	w req	lete	ASCUD								24a. Was an	24h W	ere autoo	sy findings ava	allable
Ä	Physician: The lav this certificate hes al director, page 2	Completed									autopsy performe	ed? de	or to com	pletion of caus	se of
ā	iffication, pa		25. Was case referred to medical	1					26 Place o	of Death /	1 Yes 2 Check only one		Yes 2	∐ No	
<u>=</u>	ysicia s cer direct	To Be	examiner? 1 ☐ Yes 2 ☐ Mo	Hospital: 1 [	Inpatient 2	☐ ER/Outpatier	nt 3□ DO	A Othe			5 Residen		(Specify)		
0	Attending Physician: It death. Sotor: After this certifice by the funeral director, I		27. Manner of Death	28a. Date	of Injury oth, Day Year)	28b. Time o	f 2	8c. Injury Work	at		d. Describe how				
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Division of Vital Records,	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	art 289. Place	e of Injury · At ling, etc. (Spec	home, farm, sti	eel, factory	, office		28	f. Location (Stre City or Town,		or Rural	Route Number	r,
	urs el								-						
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	To the Hospital or Attending Phys within 24 hours eiter death. To the Funeral Director: Alier this compietely filled in by the funeral director.	Me	29b. Signature and title of certifier				290	. License	number		290	d. Date signed	(Month, D	ey, Year)	
	^		1 20 an	M. D				1) 5	579	52		7/7/	06		
	m		30. Name and address of person wh	no completed cau	use of death (Ite	om 23a) (Type,	Print)		•				•		
1	1.1		Babuld San.	M.D. 1	06 Mil	ford ST.	#5	041	3, 5,	Lisb	hy	MD 218	504		
	Sta Registr		29b. Signature and title of certifier  20 an  30. Name and address of person wh  Babwal San.  31. Date filed (Month, Day, Year)  JUL 1	32.1	Redistrar's Sign	nature	1 1								
	ricgion		JOLIU	40001	W. BRILLEY	11.	MARACI	1							

DHMH 17 Rev 1/2001

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Francis Marc Hayman	State of Maryland / Department of Health and Mental Hygiene
4 Far Chata	0 (15) 1 5 0 11

		For State Certific	cate of Death		3. No. 201	15 2301
Physicia	ın/	Decedent's Name (First, Middle,Last)		Date of Death     Month	Day Year	3. Time of Death
Medical Exami	ner	Francis Marc Hayman  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De	July 11, 20	06 4c. County of Death	1300 hrs
		Route 404 @ Deep Shore Road	Denton	saul	Caroline	
Funeral		Social Security Number	irthday) If Under 1 Year If Under 24	Hrs. 8. Date of Birth		hplace (State or
Director		215-50-8156 1xm 2 F 43	Yrs. Months Days Hours	Min. July 24,	1962 Foreig	n <sup>untry</sup> Delaware
any		Usual Residence of Decedent         10a. State         10b. County         10c. City, Tow	n or Location			10d. Inside City Limits
<b>*</b>	_	Maryland Caroline Dens	Con			1 Yes 2 No
Maryland 28a-f show d at once.	Director	10e. Street and Number	10f. Zip Code	10	g. Citizen of What Cour	ntry?
th the Maryland 23a or 28a-f sho notified at once.	힐	111 Martha Jane Street	21629	Ш	nited State	es of Americ
215-0036 be filed within 72 hours after death with the Maryland nital Hygiene. rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No	13. Was Decedent of Hispanic Origin? If Yes, specify Cuban, Mexican, Pu		14. Race - Ameri White, etc.	can Indian, Black,
after	Đ F	Widowed 4 Divorced If Yes, Give Year or Dates:	1 Yes 2 X No specify:		Specify: Cauc	casian
hours natur		15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4 or 5+)	<ul> <li>Decedent's Usual Occupation (Give kind during most of working life, DO NOT use</li> </ul>		16b. Kind of Business/I	
36 hin 72 e. than '	Completed	12	Postal Clerk		United Sta	ites Postal
sed with	흥	17. Father's Name (First, Middle, Last)	18.Mother's N	ame (First, Middle, M		£
21215-0036 uld be filed within 72 Mental Hygiene. marked other than 'c event, the Medical	Be	Francis Martin Hayman		et Lee Col		
	7	19a. Informant's Name/Relationship (Type, Print)  Marsha R. Hayman Wife	9b. Mailing Address (Street and Number 111 Martha Jane Str			
and 2 shou tealth and N			e of Disposition (Name of cemetery,	Date Date	20c. Location - City or	
5 2 2 2 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		D. A	atory or other place)	114/2004	Donton M.	u a / sum ol
Baltimo permit. Page Department o Important:		21. Sign - ure of Funeral Service Lic - e	on Cemetery 7/ 22. Name and Address of Facility	16/2006	Denton, Mo	vykana
Dem Dem Dem Injurie		, and offil, low	Moore Fyneral Ho	oma, P.A.D	enton. Mari	land 21629
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/Medical Examiner		Immediate Cause (Final disease a. Multiple Injuries				Death
•		or condition resulting in death)  Due to (or as a consequence of):				
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Box 687  e death certifit  the attending i	iciar	past 12 months?  4 Pregnant at time of death	5 Other (Specify)	griancy	MOTET	real real
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COFC law re has be	Completed			autops perform	ned? death?	completion of cause of
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1 of \ling Phy After the	-	27. Manner of Death 28a Date of Injury (Month, Day Year) 28l	o. Time of Injury 28c Injury at Work?		ow injury occurred notorcycle in colli:	sion
ion rtendii leath tor: /	atio	1 Natural 5 Pending Jul 11, 2006 Year) 12  ✓ Accident Investigation	48 hrs 1 X Yes 2 No	, Operator or r		51011
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[E] & S E	al Ce	29a Certifier (Check only 1 Certifying Physician: To the best of my knowledge, c		and due to the cause	e(s) and manner as start	
To the Hos within 24 h To the Fur completely	ledical	one) 2 Medical Examiner: On the basis of examination and/o and manner stated  29b. Signature and title of certifier	29c. License number	ed at the time, date a		
	Σ	29b. Signature and title of certifier	O.C.M.E.		July 12, 2006	itti, Day. fear)
		30 Name and address of person who completed cause of death (Item 23a	i)			
		Patricia Aronica-Pollak MD. Assistant Medical Exa	miner 111 Penn Street, Baltir	more, MD 21201		
S Regis	tate trar	31. Date filed (Month, Day-Year) 2006 32. Registrar's Signature				
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			For State Registrar	State of	f Marylan				ealth a Death	and Me		iene, og. No.	2006	5 23017	Ī
	61		1. Decedent's Name (First, Middle, Last)								2. Date of Deal Month	h Day	Year	3. Time of Death	_
	Physicia /Medic		EVELYN LORETTA J	AMIESO	N						JULY 6.	_200	)6	9:55 A M	
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			CIVISTA MEDICAL  5. Social Security Number 6. Secur		7. Age (In yrs.	last highday)	LA If Under	PLAT	A If Under 2	24 Hrs.	8. Date of Birth	_	IARLES	irthplace (State or Foreign	_
	Funeral Director			M 2 <b>∏</b> F	60 . Age (m y/s.	Yrs.	Months	Days	Hours	Min.	(Month, Day,	Year)		MARYLAND	
			Usual Residence of Decedent								JIA III IIJAA	. 20,	1740 [	MILLAND	
	yland how		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits	
	Ba-f-	cto	MD CHARLES		POR	r Tobacci	)							1 XYes 2 No	
	ith th	Director	10e. Street and Number				10f. Zip	Code			1	0g. Citiz	zen of What (	Country?	
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<u></u>			1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from	State	emetery, cren CATULIDI	-	-		TITV 1	0, 2006 1	<b>/</b>	сите м	ADVI AND	
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X R R	eath certific ettending p I for use as	7	23b. was decedent pregnant		tcome of pregnation		Ectopic p	regnancy				2	23d. Date of d		
	deal	Physician/Me	in the past 12 months? 1 🗆 Yes 2 💽 No		ant at time of o		Other (se						Month	Day Year	
л О	at the ded by the estached	Phy	9 Unknown <sup>22</sup>			h!==!==h==			- i- D i		One Dida			1- th	
	res tha signed I be de	<u>آم</u>	Part II. Other significant conditions co	ntributing to d	eath but not res	suiting in the ur	nderlying o	ause give	en in Paπ i.			es 2[		to the cause of death?  Probably 4 DUnknown	
Ö	w require been signature	etec	\								-		-		_
ě	e lew has t	Completed									24a. Was a autops perfor	SV	24b. Were pnor to death	autopsy findings available o completion of cause of ?	į.
Vital Records,		e Co	OS Was soon interest to modical									2X No	1 🗆 Ye	es 2□ No	
	sicia certi irecto	8	25. Was case referred to medical examiner? 1 ☐ Yes 2 📉 No	Hospital:	Inpatient 2	ER/Outpatien	t 3□ D	Othe	25		(Check only or ne 5 ☐ Resid		COther (Co	20064	_
0	g Physie this neral di	n: To	27. Manner of Death	- T · · · · · · · · · · · · · · · · · ·	of Injury th, Day Year)	28b. Time of		28c. Injury Work			8d. Describe h			Decity)	
0	tending I death. tor: After the funer	atio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(MOII	III, Day 19ai)	Injury	м		Yes 2	No					
Division of	or Attend efter death Director: /	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place	of Injury - At h	ome, farm, str	eet, factor	y, office		2	8f. Location (S City or Tow			Rural Route Number,	
	To the Hospital or Attending Physician: within 24 hours effer death. To the Funeral Director: After this certific completely filled in by the funeral director.														
	Hosp 14 hou Fune tely fil	Icai	29a. Certifier 17 Certifying Phy (Check only 2 Medical Exam	iner: On the b	asis of examina										
	To the Hospital within 24 hours e To the Funeral I completely filled	Medical	one) 29b. Signature and title of certifier	and man	ner stated.		29	c. License	e number		2	9d. Dat	e signed (Mo	nth, Day, Year)	_
	ĕ∓≼∺		Nah-	Path	n MU	>		-522					1716		
(			30. Name and address of person who c	ompleted caus	se of death (Ite	m 23a) (Type.							10		
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	Regist	rar	1111 11 7	2006	Chillian Comment	19	11111								

				1 - For State Registrer	State of	Marylan	•	artmen rtificat				lental Hy	giene	2006	23018
		Physicia	. n	1. Decedent's Name (First, Middle, La	•							2. Date of De Month	aath Day	Year	3. Time of Death
4		/Medic		Bernice LaRue			ohnson					July	5	2006	8:20 a M
		Examin	er	4a. Facility Name (If not institution, giv			- 10		Town, or Bel	Location	of Death		4c. Co	ounty of Death Harf	ord
				Upper Chesapeak  5. Social Security Number 6.5		Age (In yrs.		If Under		If Under	24 Hrs.	8. Date of Bi	rth		
		Funeral			1 □ M 2 🛣 F	84	Yrs.	Months		Hours	Min.	(Month, Di	ay, Year)	O1 PA	place (State or Foreign ntry) nnsylvania
	ь	Director		Usual Residence of Decedent		0-1						000. 1	1, 102	1 16	illisyivaniia
0		/land		10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
~		Mar.	tor	Maryland Harf	ord			На	vre	de Gr	ace				1X Yes 2 □ No
5		or 28	lrec	10e. Street and Number				10f. Zip	Code				10g. Citize	n of What Cou	ntry?
-		th will	alD	106-22 Bayland I	Orive					2107	8			U.S.A	Α.
25 am	•	- dea	Funeral Director	11. Marital Status	12. Was Deced	ent Ever in U. es?	.S. 13.	Was Dece	dent of Hi	ispanic Or ın, Mexicai	igin? (Sp	ecify Yes or N Rican, etc.)	0- 14	. Race - Ameri Black, White	
3	36	or It		1 ☐ Never Married 2 ☑ Married	1 Tes 2 If Yes, Give Year or Date	<b>⊠</b> No		1 🗆 Yes						pecify: T	Th ÷ + o
LR	215-0036	within 72 hours etter death with the Maryland ene "tentural", or terme 23a or 28a-1 ehow than Madical Examinar must be notified at	d by	3 ☐ Widowed 4 ☐ Divorced	J	9S:	16a. Dece	dont's Hau	al Occup	ation			16h Kind	of Business/Ir	White
4	5	n 72	Completed	(Specify only highest gr	ade completed)		(Give	kind of wo	rk done d se retired	du <i>ring</i> mos f)	t of work	ing	1	ern Ele	* .
	12	yiene.	Juo	Elementary/Secondary (0-12) Twelve Years	College (1-4	or 5+)		sembl					Aller	town, P	ennsylvania
	0	filed with Hygiene other the	Be C	17. Father's Name (First, Middle, Last	)			- C				e (First, Middle	, Maiden Si	ımame)	
	lan	lid be lental ked c	ToB	Lewis	O. Heint:	zelman						Ma	ry Sny	der	
	Maryland 21	nd 2 should be filed ith and Mental Hygis 27 is marked other r freumatic event, it	Γ.	19a. Informant's Name/Relationship	Type, Print)		19b. Maili	ng Address	(Street	and Numb	er or Rur	al Route Numb	per, City or 7	own, State, Zi	p Code)
	Σ	Heelth a Heelth a Iem 27 is		John S. Johnson	(Husband	-	_		-		.ve,	Havre	de Gra	ace, MD	21078
	ore	es 1 and of Heeltl f Item 2: r other f		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ∫	Domoust from Ct	20b. F	Place of Dispo emetery, crei	sition (Name	me of other plac	(e)		Date	20c. Loca	ition - City or T	own, State
	Ĕ	Pages nent of ent: If It ury or o		4 Donation 5 Other (Speci			atedal	e Cen	neter	cy	07/1	.0/06	Slate	dale, E	ennsylvania
	Baltimore,	permit. Pages 1 Department of Ho Importent: If Ites any injury or oth		21. Signature of Funeral Service Lic	nsee	/		2. Name ar				Son Fun	eral	Home F	P . A .
	ш_	40 E E G		23a. Part1. Enter the disease, or con	tille	201/06									
				SHOCK, OF HEART RAILUIG. EIST OFFI	one cause on ear	used the deat ch line.	h. Do not en	ter the mod	de of dyin	ng, such as	cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
		Physician		Immediate Cause (Final disease or condition resulting in death)	a A5.	pivat	ion	Pn	eu	mo	から	9			
raw		/Medical Examiner		Tesuming in death)	Due to (o	as a conseq	uence of):	H		ato	3000	24			
1 /			er	Sequentially list conditions,	b. Due to (o	r as a conseq	uence of):	010	_ / / / (	aio	rra	1		-	
		uted nsit	UL L	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			, ,								
	Ć,	be executed sicien and burial-transit	Examln	that initiated events resulting in death) Last	Due to (o	r as a conseq	uence of):								
	760,	<u>u</u> = <u>c</u> u	cal	(	d										
	Вох 68	leath certifical attending phy I for use as th	an/N	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outco	ome of pregnath 2 🗀 Feta		⊒Ectopic p	regnancy	/			23	d. Date of deliv	
		ne dea the att	sicia	in the past 12 months? 1 ☐ Yes 2 No	4☐Pregnar	nt at time of d	leath 5[	Other (s	pecify) _					Month	Day Year
5	<u>P</u>	that the ded by the deteched	Physician/Med	9 Unknown		Ab b. A A	u talin n lin atoni					220 Did	tebagg up		the cause of death?
hnso	Records, P.O.	es De	Š	Part II. Other significant conditions	contributing to dea	ith but not res	ulling in the u	inderlying	cause giv	en in Part	1.				bably 4 Dunknown
ج	orc	w requi	eted									-		,	
٥	Sec.	e law has t	Completed									24a. Wa auto	s an opsy formed?	24b. Were aut prior to o death?	opsy findings available ompletion of cause of
7	a F	cete											2000	1 Yes	250 No
a	Vit.	ysician: The l is cartificate he director, page	Be	25. Was case referred to medical examiner?	Hospital: 🗽				Oth			th (Check only			
ن	ō	Phys rthis ral dii	2	1 Tyes 25 No 27. Manner of Death	28a. Date of (Month		28b. Time of		28c. Injur Wor	y at	ursing He	ome 5 Res			ity)
ernic	on	ding th. Afte	tlor	Natural 5 Pending 2 Accident investigation		, Day Year)	Injury	м		rk? Yes 2.[	]No				
E	Division of Vital	Atter r dea ector by the	Ifica	3 Suicide 6 Could not determine	4 28e. Place	of Injury - At h	ome, farm, st	reet, factor	y, office				(Street and own, State)	Number or Ru	ral Route Number,
(-3)	Ö	s afte	Certification:	4   Homicide	building	g, etc. (Speci	(y)					City of 1	Jwii, State)		
		To the Hospital or Attending Phys within 24 hours after death. To the Funeral Director: After this compiataly filled in by the funeral di	edical (		hysicien: To the teminer: On the bas										
		the H nin 24 the F the F	led	one)	and manne		ation and or it					700 01 1110			, ,
4		Vill To To	Σ	29b. Signature and title of certilier				29	\	se number	201	15	Zad. Date	signed (Month	) Cay, rear)
						>		1	100	06	500	+ ~	_//	3/1	6
		6		30. Name and address of person who Irina Mikityanska	•				no sl	. D~	i 170	Bo1 7.4	20 Mars	w.r.l a.e3	21014
		St.	ate	31. Date filed (Month, Day, Year)	32. Re	gistrar's Sign	ature		, pear	re DE	rve,	DET AI	r, Ma	ryrand	Z1U14
		Regist		JUL 7 2006	Ken	JE A	porte								

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dav **Physician** 5:25 P M Mildred Virginia Jones 2006 4c. County of Death July 5. /Medical 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Calvert Memorial Hospital Prince Frederick Calvert 9. Birthplace (State or Foreign 27, 1924 Virginia 8. Date of Birth 7. Age (In yrs. last birthday) 5. Social Security Number Funeral Months Days 1 ☐ M 2 ☐ XF 81 December Director 577**-**26-3162 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other then "neturel", or tiems 23a or 28a-f show any injury or other treumatic event, the Medical Examiner mast be multilised at once. 1 ☐ Yes 2 ☐ No Maryland St. Mary's Mechanicsville Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 38580 Laurel Ridge Drive 20659 U.S. A. 14. Race - American Indian, Be Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give X Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: White Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 🕏 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) U.S. Government Statistical Clerk 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Ashbey Lee Malone Mary Ellen Weaver 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 15235 Oaks Rd., Charlotte Hall, MD 20622 Carole A. Bright/daughter 20b. Place of Disposition (Name of cometery, crematory or other place)
Brinsfield-Echols Crem. Date 20c. Location - City or Town, State MD 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) July 11,2006 Charlotte Hall, 22. Name and Address of FacilityBrinsfield-Echols F.H., P.A., 21, Signature of Funeral Service Licensee MO0641 30195 Three Notch Rd., Charlotte Hall, MD 20622 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Hemorrhagic Physician /Medical Due to (or as a consequence **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medical Examiner sician and e burial-transit Due to (or as a consequence of) Box 68760, phys. the b IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes PNo
9 Unknown 4☐ Pregnant at time of death 5 Other (specify) P.O. I 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Completed by 2 No 3 Probably 4 □Unknown 1 ☐ Yes 245. Were autopsy findings available prior to completion of cause of death? 24a. Was an performed? /es 2 No 1 ☐ Yes 2 ☐ No To the Hospitel or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? Be Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3□ DOA 1 🗌 Yes ↑ ☐ Impatient Certification: To 28d. Describe how injury occurred 27. Mann of Death 28b. Time of atural 5 Pending s after death. 1 ☐ Yes 2 ☐ No 2 Accident investigation Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of ceptifier D0060475 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ROAD, PRINCE FREDERICK MD 20678 BUSH 100 HOSPITAL TEREZIA 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			For State Registrar	State of Ma	aryland /		rtment tificate					Reg. No.	/ ii l l in		020
	Physicia	an	1. Decedent's Name (First, Middle, L								2. Date of De Month	Day		3. Time o	
	/Medic	al -	William B. Jacks  4a. Facility Name (If not institution, g				Ab Ciby T	01100 05	Location of		July	6,	2006 County of Deat	4:00	РМ
	Examin	ÇI	3981 High Point F						tt Ci				vard		
	Funeral			Sex 7. Age	e (In yrs. last	birthday)	If Under 1	Year	If Under 2	_=_	8. Date of Bi (Month, D			hplace (State ountry)	or Foreign
	Director		213 20 2493	X <sup>™ 2□ F</sup> 8	1	Yrs.	Months	Days	Hours	Min. {	B/11/1	924		land	
	pug *	ŀ	Usual Residence of Decedent  10a. State 10b. County		10c. City, To	own or Lo	cation							10d. Inside C	ity Limits
	Maryla febo	5					t City							1 🗆 Yes	2 <b>√</b> No
	r 28a	rec	MD Howard  10e. Street and Number		الماليل ا	IQU	10f. Zip (					10g. Citi	zen of What Co	untry?	
	th witt	Funeral Director	3981 High Point	Rd.			2	2104	2			US	SA		
	r dea	ner	11. Marital Status	12. Was Decedent Armed Forces?		13.	Was Decede f Yes, specif	ent of His fy Cubar	spanic Orig	gin? (Spec , Puerto P	cify Yes or N lican, etc.)	0-	14. Race - Ame Black, White		
36	hours after death with the Maryland tural, or Itama 23a or 28a-f ehow al Examiner must be motified at	by Fi	1 ☐ Never Married 2 ☐ Married 3 🕍 Widowed 4 ☐ Divorced	1 SYes 2 ☐ N If Yes, Give Year or Dates:			1 ☐ Yes 2	₹No	Specify:				Specify: W	nite	
Ş	thouse the search	ed t	15. Decedent's	Education			dent's Usual					16b. Kii	nd of Business/	Industry	
215	hin 72 9. Medi	piet	(Specify only highest of Elementary/Secondary (0-12)	grade completed)  College (1-4or 5	5+)	(Give life.	kind of work DO NOT use	done d retired)	luring most )	of workin	g				
2	ygien ygien her th	Completed		4		Phan	nacist					1	etail		
gue	be fit ntal H od ott	Be	17. Father's Name (First, Middle, La William B. Jac								(First, Middle abeth				
Maryland 21215-0036	should be and Mental I marked or umatic eve	은	19a. Informant's Name/Relationship		1	9b. Mailir	na Address						r Town, State, Z	Zip Code)	
<u>8</u>	nd 2 salth ar		Eileen Kalwa/nie		5	906 1	Dale C	t.	Syke	svil	le, MD	217	784		
ore,	of Hear		20a. Method of Disposition	DD	20b. Place ceme	of Dispo	sition (Name	e of her place	e)	Da	ate	20c. Lo	cation - City or	Town, Stete	
Ē	Page nent ant: If ury or		1 😡 Burial 2 □ Cremation 3 1 4 □ Donation 5 □ Other (Spe	cify)	Cres						/2006		iottsvi		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Healith and Merital Hygiene. Department of Healith and Merital Hygiene "natural", or Itama 23a or 28a-f show Important: If item 27 is marked other then "natural", or Itama 23a or 28a-f show any injury or other traumatic event, the Medical Examinar must be notified at ORGS.		21. Signature of Funeral Service Lic	7 / 1	01442	4:	2. Name and 112 O1	Addres	s of Facility  Lumb	y Harı ia Pl	ry H.	Witzk licot	ce's Far t City	nily FH , MD 2	Inc. 1043
# 	Physician		23a. Part . Enter the disease, or co shock, or heart failure. List on Immediate Cause (Final disease or condition resulting in death)	a. Cok NA	ne. Ry Ak							arrest,		Approxima Interval Be Onset and	tween
ē	/Medical Examiner			b. ABDAR		ce of):	y Di RTIC	A	NEUL	reysa	1			YEA	مع
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	a consequent	ba of).									
,092	eath certificate be executed attending physician and for use as the burial-transit	cai Exa	resulting in death) Last	Due to (or as	a consequen	ce of):									
687				0.			co cardinalis su								
ŏ	endin endin	M/UE	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 □ Live birth			Ectopic pre	onancy				2	23d. Date of del		v
P.O. Box	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as t	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at 9□ Unknown			Other (spe						Month	Day	Year
	s that pned b	by PI	Part II. Other significant condition	-		-		-			23e. Did	tobacco u	se contribute to	the cause of	death?
ğ	w require been sig should b	ted t	METASTATIC CA			AL.	SEPT	un	WITH	<del></del>	1 🗆	Yes 2	□No 3□Pr	obably 4 🗍	Unknown
ecc	e law ra has be je 2 sh	Completed	METASTASIS to A	J. MANDIBL	£ .						24a. Wa auto	OOSY	prior to	topsy findings	available cause of
E B	: The cate h		CARCINOMA OF	PROSTATE ,	SIPI	RABI.	ATTON	740	CKAPY	V		ormed? 2∑No	death?	2 X No	
Z.	ding Physician: The lar h. After this certificate has funeral director, page 2	o Be	25. Was case referred to medical examiner?	Hospital:				Othe	ar		(Check only		- Fou (0		
of	Phys ar this aral di	-	1 ☐ Yes 2 ☒No 27. Manner of Death	28a. Date of Inju		b. Time o	nt 3 DO/	Bc. Injury	/ at		8d. Describe		6 □Other ( <i>Spe</i> y occurred	ciry)	
ion	nding Path. r: After e funer	atlo	1 XNaturat 5 ☐ Pending 2 ☐ Accident investiga		y rear)	Injury	М	Work 1 □ \	<br Yes 2 □ h	No					
Division of Vital Records,	al or Atten s after death I Director: d in by the	Certification;	3 ☐ Suicide 6 ☐ Could no 4 ☐ Homicide determin	286. Place of In	jury - At home tc. <i>(Specify)</i>	, farm, st	reet, factory,	, office		2		(Street an own, State	d Number or Ru )	ırai Route Nur	nber,
	To the Hospital or Attending Physician: within 24 hours after death.  To the Funeral Director: After this certifical completely filled in by the funeral director,	edical (		Physician: To the best kaminer: On the basis of and manner st	of examination										s)
	To the To the comp	ž	29b. Signature and title of certifier						number				e signed (Mont) 7/2006	h, Day, Year)	
,			I somme la	in , Mas				DZ	283	2			1/2000		
(	20 E.G		30. Name and address of person w	3 .	death (Item 23	(Type,	Print)	. 1 .	(n		ヒル	110-	an A	TIAME	
	Sta	ate	Shan JA  31. Date filed (Month, Day, Year)	Kim i Mi	rar's Signature	580	O MA	1~ 2	TREE	-1 , 1	ELKRI	NE	, mb	210/1	
10	Regist		JUL 7	2006	rar's Signature	K /	Court !	,							

		_ 1	State of Maryland / [ State Registrar	Оера		of H	ealth a		ental Hyg	Reg. No.	006	1 10 10 to 1
*#q	Physicia	an	Decedent's Name (First, Middle, Last)     ARTHUR JOSEPH KRISE						2. Date of Dea Month June 28	Day	Year 16	3. Time of Death 2:25 р м
	/Medic Examin		4a. Facility Name (If not institution, give street and number) Washington Adventist Hospital				Location o	rk		4c. Cou	ontgom	ery
	Funeral Director		210-03-4077	thday) Yrs.	If Under Months	1 Year Days	If Under a	24 Hrs. Min.	8. Date of Birt (Month, Day 10/6/19	Year)	Cou	place (State or Foreign ntry) sylvania
	Maryland f show		Usual Residence of Decedent  10a. State 10b. County 10c. City, Tow  Maryland Prince George's Riv		cation lale							10d. Inside City Limits 1X Yes 2 □ No
	or 28a-	Director	10e. Street and Number		10f. Zip		0.7			_	of What Cou	ntry?
36	iges 1 and 2 should be filed within 72 hours after death with the Maryland to Health and Mental Hyglene. If item 27 is marked other than "natural", or Items 23a or 28a-f show or other traumatic avent, the Medical Examinat must be notified at	rai	11. Marital Status  1 □ Never Married 2 □ Married  1 □ Never Married 4 □ Discord  1 □ Yes, Give		Was Deced If Yes, spec		spanic Orig n, Mexican		ocify Yes or No- Rican, etc.)		Race - Amen Black, White,	
Baltimore, Maryland 21215-0036	ithin 72 hours ne. nan "natural" nedical Ex	Completed b	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	dent's Usua kind of wor DO NOT us Mach	rk done a se retired,	luring mosi )	t of workii	ng		of Business/Ir	
1d 21	e filed w Il Hygier other th	Be Cor	12 17. Father's Name (First, Middle, Last)		Macn	Inis	18. Mothe		(First, Middle,	Maiden Sui		uustiy
ylan	outd be I Menta narked natic sv	To B	Bennett B. Krise	Maili	na Address	(Street 2			Unknowr		own State Zi	Code)
Mar	alth and 27 is n								belt, M		770	
more,	permit. Pages 1 and 2 Department of Health a Important: If itsm 27 is any injury or other tra		20a. Method of Disposition  1  Burial 2  Cremation 3  Removal from State  4  Donation 5 Other (Specify)	ry, cre	matory or o	ther plac			2006		ion - City or T andria	own, State , Virginia
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Vital	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			Oth	0.5		Check only			
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R	(12)		30. Name and ad of erson who completed carry of a ath (Item 23a Dpinder Singh, MD 14300 Galla			ane,	Ste	12,	Bowie,	MD 2	0715	
County of the last	St Regist	ate rar	31. Date filed (Month, Day, Year)  JUL 0 6 2006  2. Registrar's Signature	for	W							

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 5, 1:05 A M 2006 Irene M. Koniuszy /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Annapolis Anne Arundel 856 Scenic Hills Way If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year 6/27/1922 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 □ M 2 XF Illinois Director 356-09-6695 84 Usual Residence of Decedent deeth with the Maryland permit. Pages 1 end 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 is marked other then "naturel; or iteme 23e or 28a-f show any Injury or other traumatic event, the Medical Examinar must be notified at once. 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Anne Arundel Annapolis 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 856 Scenic Hills Way USA Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: 3 

Widowed 4 □ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 8th Homemaker Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Albert Kluska Josephine Dyba ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia A. Garrett/ Daughter 856 Scenic Hills Way, Annapolis, MD 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 7-5-06 Kalas Crematory Edgewater, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility George P. Kalas Funeral Home 21. Signature of Furteral Service Licensee MA 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Onset and Death Immediate Cause (Final disease or condition resulting in death) MUCER **Physician** LUNG 3 mos /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit resulting in death) Last Due to (or as a consequence ol): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1☐Live birth 2☐Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy igned by the atte in the past 12 months? Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 4 Yes 2 No 3 Probably 4 Unknown Completed page 2 should peen 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed 1 Yes 2 No 1 Yes 2 No Hospital or Attending Physician: filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 Yes 2 10 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred Certification: 28c. Injury at Work? 1 Matural 5 Pending investigation 2 Accident 24 hours after deat Funeral Director: 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 5, 2006 DC8116 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) PIESTOPTE PD BONNMILLS JM 21407 MATILINS JAN 197 900 31. Date liled (Month, Day, Year) egistrar's Signature State JUL 0 6 2006 Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

Certificate of Death 2006 23023

		Registrar					Cert	инсате с	Dea	://				Reg No			
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical	UNPENDED	)		AMENDED												
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Division To the Hospital or Attenc within 24 hours after death To the Funeral Director:	Medical		Medical Exa	miner	on the basis	of exam											ause(s)
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186		Mary G. R/n			uty Chief	-				Street,	Baltimo	ore, MD	21201				
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Regist	(E)	<u></u>	JUL 0	1 4	006												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 3 , July 2006 Betty Irene Keyser 10:30 AM 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Frederick Memorial Hospital Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 15, 1930 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days 1 ☐ M 2 💢 F 213-24-8979 76 Maryland Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits Maryland Frederick New Market 1 ☐ Yes 2 X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21774 10203, B, White Pelican Way United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☒ No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker her home 9 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) William Stevens Mary Magdalene Tyeryar 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Austin Keyser / Husband 10203 B, White Pelican Way / New Market, MD 21774 L. 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mount Olivet Cem. 07/07/2006 Frederick, MD 21. Signature of Funeral Service Liousee 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 1621 Opossumtown Pike/ Frederick, MD 23a. Part1 the the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shops, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) a Chts micardist

Due to (or as a consequence of): minule

**Physician** /Medical Examiner

**Physician** 

/Medical

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permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel; or items 23s or 28s-f show aptifury or other treumatic event, the Madical Examinat must be notified at once.

Baltimore, Maryland 21215-0036

Be Completed by Physician/Medical Examiner Hospital or Attending Physician: The law requires that the death certificate be executed Medical Certification: To efter death.

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Division of Vital Records, P.O. Box 68760,

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect		clistes		
IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome of pregn 1 □ Live birth 2 □ Fet 4 □ Pregnant at time of ( 9 □ Unknown	al death 3 Ectopic pre			23d. Date of delivery Month Day Year
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examiner? 1 Yes 2 No	lospital: 1 Alcpatient 2 □	ER/Outpatient 3 DO.	Other: 4 Nursing	Home 5 ☐ Residenc	e 6 □Other (Specify)
27. Manner of Death  1. Matural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	ic. Injury at Work? 1 Yes 2 No	28d. Describe how	
3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At h building, etc. (Speci	ome, farm, street, factory,	office	28f. Location (Stree City or Town, S	at and Number or Rural Route Number, State)
29a. Centifier 1 Centifying Physical Canada (Check only one) 2 Medical Examil	sician: To the best of my known to the basis of examination and manner stated.	owledge, death occurred a ation and/or investigation.	t the time, date and place in my opinion, death occ	ce, and due to the caus curred at the time, date	se(s) and manner as stated. and place, and due to the cause(s)
29b. Signature and title of certifier	1	29c.	License number	29d.	Date signed (Month, Day, Year)

State

Registrar

31. Date filed (Month, Day, Year)

JUI 1 0 2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death Decedent's Name (First, Middle, Last) **Physician** July Allison Kelly 2006 9:25 P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Beverly Healthcare Frederick Frederick If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1 € M 2 □ F 18, 1923 Washington, D.C Yrs. July 82 Director 578-20-6687 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits iral, or items 23s or 28s-f show Examiner must be notified at 1 ☐ Yes 2 ☐ No Completed by Funeral Director Frederick Maryland Frederick 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number death with United States 21703 6961 Rooks Court, Apt. 105 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status permit. Pages 1 and 2 should be fited within 72 hours after of Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iter any injury or other treumatic event, its Medical Exertirat Agre. 1XYes 2 □ No World
If Yes, Give
Year or Dates:War II 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Electical Engineer Government 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Jessie Dunn Foster R. Kelly ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 6961 Rooks Court, Apt. 105, Frederick, MD 21703 Jane M. Kelly / Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Frederick Crematory 7/5/2006 Frederick, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Home 21. Signature of Funeral Service Licenses 1621 Opossumtown Pike, Frederick, MD 21702 23a. Part Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. ountry Approximate Interval Between Onset and Death Immediate Cause (Final Se **Physician** Week disease or condition resulting in death) /Medical Due to (or as a consequence Examiner Sequentially list conditions, I a.y. leaving Unincipals cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examiner law requires that the death certificate be executed use as the burial-transit and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 Ø No 4 Pregnant at time of death 5 Other (specify) detached 9☐ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an er ten och autopsy performe 1 Yes 2 No the funeral director, 25. Was case 26. Place of Death (Check only one) examiner: 1 Yes 2 No Other: 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other (Specify) this 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☑ No after death. investigation 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours at To the Funeral D completely filled i 29a. Certifier The Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Shah Hoon 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick 32/Degistrar's Signat Je State Registrar

			For State Registrar	State of Maryland		rtment of H			giene Reg. No. 2	006	23025
	也		1. Decedent's Name (First, Middle, Last)					2. Date of De		Vana	3. Time of Death
	Physicia		Frederick Arthu	r Lupton, Jr				July	3 Day	2006	3:45 P M
	/Medic Examin		4a. Facility Name (If not institution, give si	treet and number)		4b. City, Town, or	Location of Death	1	4c. Co	ounty of Death	
		Ŭ.	Heritage Harbour C	enter		Annar	oolis		An	ne Aru	ndel
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	t birthday)	If Under 1 Year		8. Date of Bir (Month, Da	th V Year)	9. Birth	place (State or Foreign
	Director		241-07-0246	M 2□F 88	Yrs.	Months Days	Hours Min.	Feb. 6	<b>,</b> 1918		h Carolina
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	or 28	Director	10e. Street and Number			10f. Zip Code			10g. Citize	n of What Cou	ntry?
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و	if it		1 N Burial 2 ☐ Cremation 3 ☐ Re	emoval from State	netery, cren	natory or other place		1 /2006			
Baltimore,	permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "naturel; or items 23a or 28a-f show any injury or other traumatic event, it is Mudical Examinat must be notified at anone.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service License	^		Nat. Cen	15 30	21/2006		ngton,	VA.
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Λ	111		30. Name and address of person who co	mpleted cause of death (Item 2	23a) (Type	Print)		- 10			•
_	D 14		Mirza M. Nusairee			on Center	c Croft	on, MD.	211	14	
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Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Anthony Ameen Littleton

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*	Physici	30	1. Decedent's Name (First, Middle, Las	)				2. Date of Death Month	Day Yea	
	/Medic	al	Francis I. Laver			45 Ch Tour	Landing of D	June	30 200 4c. County of De	
	Examin	er	4a. Facility Name (If not institution, give Carroll Hospital			4b. City, Town, or	inster	eatri		roll
- JAN	Funeral		5. Social Security Number 6. Se	7. Age (In)	vrs. last birthday)	If Under 1 Year Months Days	If Under 24 h	Hrs. 8. Date of Birth (Month, Day,		irthplace (State or Foreign Country)
	Director		1,0 =1 000=	3M 2□F	83 Yrs.	Months Days	Hours		1923	ND
Pue	A T		Usual Residence of Decedent  10a. State 10b. County	10c.	. City, Town or Lo	cation				10d. Inside City Limits
Man	a-i	tor	MD Baltim	ore	Caton	sville				1 ☐ Yes 2X No
with the	items 23a or 28a-f ehow	i Director	10e. Street and Number 529 Wetside Blvd	ì		10f. Zip Code	21228	10	g. Citizen of What	Country? USA
400	ma 2	Funeral	11. Marital Status	12. Was Decedent Ever i Armed Forces?	n U.S. 13.	Was Decedent of Hi	ispanic Origin?	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ar Black, W	nerican Indian,
d 21215-0036	el', or it	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 📉 es 2 🗆 No		1 ☐ Yes 2 ☐ No	Specify:	derito filozii, etc.)	Specify:	White
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arylan	Mental Wental urked c	To B	Edward Laverdure				<b>Id</b> a 1	M. Piccard		
	ra i		19a. Informant's Name/Relationship (7 Ann Marie Laverdu	•		_		r Rural Route Number, Catonsville		
<u>.</u>	or other tr		20a. Method of Disposition 1 ☑Burial 2 ☐ Cremation 3 ☑	20	b. Place of Dispo				0c. Location - City	or Town, State
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			23a Part1. En er the disease, or composition shock, or heart failure. List only of	lications that caused the cone cause on each line.	death. Do not ent	er the mode of dyin	g, such as care	diac or respiratory arre	st,	Approximate Interval Between Onset and Death
	hysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	-gmph	ims				moth
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Division	after des Directo	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - Abuilding, etc. (Sp.	At home, farm, str pecify)	eet, factory, office		28f. Location (Str. City or Town,		Rural Route Number,
	to the nospital or Averlands Frishwithin 24 hours after death.  To the Funeral Director: After this completely filled in by the funeral of	edical C	29a. Certifier 1 Certifying Phyone) 2 Medical Examone)	ysician: To the best of my iner: On the basis of exam and manner stated.	knowledge, deat	n occurred at the time vestigation, in my of	ne, date and pl pinion, death o	lace, and due to the car occurred at the time, da	use(s) and manner te and place, and d	as stated. ue to the cause(s)
U.	omple	Med	29b. Signature and title of certifier	and manner stated.		29c. License	e number	29	d. Date signed (Mo	nth, Day, Year)
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	W35		30. Name and address of person who o	completed cause of death	114 0	Print)	ath A	dre Re.	Holo in	MD 21176
al l	Sta	ite	31. Date filed (Month, Day, Year)	32. Registrar's S	1	/11 = 11 W	11 1	11/04	1411	1.11.0(1)
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James Joseph Latimer

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1. For State Certificate of Death Registrar . Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month D July 9, 2006 0800 hrs Medical Examiner James Joseph Latimer <del>III</del> 4b City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Elkton Cecil 27 Chesapeake Drive 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 7 Age (In vrs. last birthday) 6. Sex **Funeral** Foreign Country) Months Davs Hours 07/12/1965 222-44-5836 DE Director 40 1 X M 2 F Usual Residence of Decedent 10d Inside City Limits 10c City, Town or Location 10b. County 10a State 1 X Yes 2 No MD Elkton or 28a-f show ified at once. Cecil death with the Maryland Director log. Citizen of What Country? 10f. Zip Code 10e. Street and Number 27 Chesapeake Apartments 21921 USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14 Race - American Indian, Black Funeral 12 Was Decedent Ever in U.S. 11. Marital Status Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White, etc. 1 X Never Married 2 Married 2 X No Yes White 1 Yes 2 X No specify Divorced If Yes. Give Year þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15 Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) it Pages I and 2 should be filed within 72 h
rment of Health and Mental Hygiene
rrtant: If item 27 is marked other than "n
y or other traumatic event, the Medical E. Disabled Disabled MD 21215-0036 18. Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) Jean Zimmerman James Joseph Latimer, Jr. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print ) James Joseph Lat mer Jr. 30 2nd Avenue, Wilmington, DE 19808 Father 20b Place of Disposition (Name of cemetery, 20c. Location - City or Town, State Date Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State Department Inportant: If 07/12/06 Linwood, PA Lawn Croft Crematory Donation 5 Other Specify: 22. Name and Address of Facility Strano & Fealby Family Funeral Home 635 Churchmans Rd Newark, DE 19702 win complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval Part I. Enter the disease, or complication failure. List only one cause on each line Physician Between Onset and /Medical Death Hypertensive atherosclerotic cardiovascular disease Immediate Cause (Final disease Fxaminer or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions Due to (or as a consequence of) if any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last nd Physician/Medical X UNPENDED physician a AMENDED item#1,23a,27,perME,g858,8/10/06 TT Box 68760 23d. Date of delivery IF FEMALE 23c. If yes, outcome of pregnancy 23b Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, P.O. þ 1 Yes 2 No 3 Probably 4 V Unknown Completed as been si 2 should b 24b. Were autopsy findings available 24a. Was an autopsy prior to completion of cause of performed? death? ✓ Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26 Place of Death (Check only one) To the Hospital or Attending Physician: Division of Vital æ Hospital: 1 Other<sub>4</sub> ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other: Scene Inpatient After this ပ 1 V Yes 28c. Injury at Work? 28a Date of Injury (Month, Day, Year 28b. Time of Injury 28d Describe how injury occurred 27. Manner of Death Certification: 1 X Natural Yes 2 No 5 Pending within 24 hours after death To the Funeral Director: the Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) determined Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started **Medical** 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) one) and manner stated 29d Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 10, 2006 O.C.M.E. 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Deputy Chief Medical Examiner Jack Titus MD.

State Registrar

31. Date filed (Month, Day, Year)

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1 Decedent's Name (First Middle Last) **Physician** Joan Elizabeth Leonard /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner A+ the icomic Hospice If Under 24 Hrs Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex **Funeral** Days Months 1 □ M 2 X F 61 225-56-7067 Va. Director August 31,1944 Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Pages 1 and 2 should be filed within 72 hours after death with the Marylan nent of Health and Mental Hygiene.
ant: if item 27 ie marked other than "naturel; or iteme 23a or 28a-1 show that it item 27 ie marked other than "naturel; or iteme 23a or 28a-1 show that yor or other traumatic event, the Madical Examinar must be notified as Md. Worcester Bishopville 1 X Yes 2 ☐ No **Funeral Director** 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9752 USA Hotel rd. 21813 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 🛣 No Specify: Specify: Black Baltimore, Maryland 21215-0036 þ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DD NDT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12th Lankford Sisco 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Ernest Lee Milbourne Gloria Elizabeth Taylor ပ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9752 Hotel rd. Bishopville, Md. 21813 Robert L. Leonard, sr./husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment of Important: If eny injury or once. 7/2/06 Antioch Church Ceme. Frankford, DE. 21. Signature of Funeral Service icensee 22. Name and Address of Facility Bennie Smith Funeral Home 917 W. Isabella st. Salisbury, Md. 21801 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart faithfie. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Dua to for as a consequence off Examiner ate hes been signed by the attending physicien and page 2 should be detached for use as the burial-transit lor Attending Physician: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Medical Certification: To Be Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 menths?

1 Yes 2 No
9 Unknown Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performer? 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 ☑ No 1 ☐ Yes the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes No 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. ate of Injury (Month, Day Year) 28d. Describe how injury occurred 28c. Injury at Work? After Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funerel Director: A completely filled in by the fu 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 🗀 Homicide Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier (Check only one) To the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 026278 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ouall, MD 1733 DEL 31. Date filed (Month, Day, Year) 32 Registrar's Signature Registrar

		1	For State Registrar		State of	Maryland		artmen tificat			and M		giene Reg. No.	000	2	3031
			1. Decedent's Name (Firs	st, Middle, La	st)							2. Date of Dea	ath Day	Year		e of Death
	Physicia /Medic		RICHARD ARL	ON LYE	ERLY, SR.							JULY	5	2006	8:	30 AM
	Examin	10	4a. Facility Name (If not in	nstitution, giv	e street and numb	er)		4b. City,	Town, or I	_ocation o	f Death			ounty of Dea		
			525 LOVE P						YENSV 1 Year		74 140 1	0.00		EN ANN		
	Funeral		5. Social Security Number		Sex   7. IM∑M 2 □ F	Age (In yrs. Ia	ast birthday) Yrs.	Months		Hours	Min.	8. Date of Birt (Month, Da 03/31/	y, Year)	NC	ountry)	ute or Foreign
	Director	-	226-52-8096 Usual Residence of Dece	)	11	64						03/31/	1742	NC		
	land ow			. County		10c. City	, Town or Lo	cation							10d. Insid	e City Limits
	the Marylan 28a-1 show	ţ	MD QU	JEEN AN	ME'S	STEV	ENSVIL	J.E							1 🗆 '	Yes 2X No
	r 28a	rec	10e. Street and Number					10f. Zip	Code				10g. Citize	n of What C	ountry?	
	h with		525 LOVE PO	INT RI	).			216	666				USA			
5-0036	s 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other then "neture!; or items 23e or 28e-f show other treumetic event, if the Modical Establish and the mullish at	by Funeral Director	11. Marital Status  1 Never Married  3 Widowed 4	2 <b>X</b> Married	12. Was Decedd Armed Forc 1 Yes 2 If Yes, Give Year or Date	es? <b>X</b> No		Was Dece f Yes, spe 1  Yes	cify Cubar	spanic Ori , Mexican Specify:	gin? (Spe i, Puerto	cify Yes or No Rican, etc.)		. Race - Am Black, Whi pecify:		n,
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Maryland	2 should be filed within and Mental Hygiene. Is marked other then eumetic event, the Mental free Menta		19a. Informant's Name/F									l Route Numb				
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altimore	Page nent c		1 <b>X</b> Burial 2 □ Cre '4 □ Donation 5 □			STEV	VENSVI	LLE C	EMETI	ERY	7/10	/2006	STEV	ENSVII	LE, M	ID
Balti	permit. Pages Department of Important: If i any injury or o		21. Signature of Funeral	Service Lice	рѕөө	9/1	P I	ELLOV O6 SI	IS, H	ELFE	MBEIN	& NEW	NAM F	UNERAL 21619	HOME	, P.A.
8760,	Physician / Medical Examiner	dical Examiner	23a. Part1. Enter the dishock, or heart fail Immediate Cause (Fina disease or condition resulting in death)  Sequentially list condition fany, leading to immediate cause. Enter Underlying Cause (Disease or injurithat initiated events resulting in death) Last	ure. List only	a. STROK Due to (o b. HYPER Due to (o c. Due to (o	ine.	uence of):  N  uence of):			, such as	cardiac	я гезрігатоту а	rrest,		Approx Interval Onset	Between and Death
P.O. Box 68	ath certificattending place use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent prein the past 12 mon 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ths?		th 2 ∏ Fetal int at time of d	Ideath 3	⊒Ectopic p ⊒ Other (s					23	d. Date of de Month	alivery Day	Year
	juires that the de n signed by the a	by	Part II. Other significan	t conditions	contributing to dea	ath but not res	ulting in the u	ınderlying	cause give	n in Part	l.			e contribute		of death?
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ita	ysicien: Th iis certificate director, pag	Be C	25. Was case referred t	o medical								(Check only				
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	To the Hospitel or A within 24 hours after To the Funerel Direct completely filled in b	edical C	29a. Certifier 1 (Check only one)	Certifying F	Physician: To the la aminer: On the ba and mann	sis of examina	wledge, dea	th occurred	d at the tim	ne, date a pinion, de	nd place, ath occur	and due to the red at the time,	cause(s) a date and p	ind manner a place, and du	s stated. e to the cau	use(s)
_	ompl	₩	29b. Signature and the	of certifier	1			29	c. License				29d. Date	signed (Mor	ith, Day, Ye	ar)
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			30. Name and address	of person wh	o completed cause	of death (Item	n 23a) (Type	, Print) "	41 R	ivor R	d, 5	te 610				
			John Ch	niste	MD.			A	nnen	olis	MT	2140	1			
	St	ate	31. Date filed (Month, C	77707	32. Re	rar's Signa	ature			,						
	Regist		J	UL ()	( Subt	Walles .	K	Lane	61							

			1- State of Marylan Registrer		artment of Health a tificate of Death		iene <sub>99. No.</sub> 2006	23032		
			Decedent's Name (First, Middle, Last)		2. Date of Deat Month		3. Time of Death			
	Physici		Elizabeth Estelle Matthews			June	29, 2006	6:00 P.M		
	/Medic Examin	_	4a. Fecility Name (If not institution, give street and number)		4b. City, Town, or Location of Death		4c. County of Death			
			Washington Adventist Hospital		Takoma Park		Montgomery			
	Funeral		Social Security Number     6. Sex     7. Age (In yrs.)	last birthday)	If Under 1 Year If Under 2 Months Days Hours	4 Hrs. 8. Date of Birth Min. (Month, Day,	Year) 9. Birthpfi	ace (State or Foreign		
В	Director		579-30-6141 1□M 2対 F 81	Yrs.	Months Days Hours	12/2/2	4 Muirk	irk,Md.		
	P		Usual Residence of Decedent							
	d within 72 hours atter death with the Maryland Jiene. r then "netural", or terne 23a or 28a-f ehow The Mudical Exaciliar must be notified at	Director		y, Town or Lo	twood		10	0d. Inside City Limits 1 2 Yes 2 ☐ No		
			Md. Prince George's	pren	LWOOD					
			3718 Allison Street	10f. Zip Code 20722			g. Citizen of What Country? U.S.A.			
		Funeral	11. Marital Status 12. Was Decedent Ever in U.	S. 13.	Was Decedent of Hispanic Orig	in? (Specify Yes or No-	14. Race - America			
36	urs atter	by Fur	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:		f Yes, specify Cuban, Mexican, 1 ☐ Yes <b>2</b> € No Specify:	Puerto Hican, etc.)	Specify: Bla	_		
Ö	2 hou	To Be Completed	15. Decedent's Education	16a. Dece	dent's Usual Occupation		16b. Kind of Business/Ind	lustry		
75	within 7. ene. then "n		(Specify only highest grade completed)  (Give kind of work done during most of working life. DO NOT use retired)  (Give kind of work done during most of working life. DO NOT use retired)							
7	d with		9th	Teac	hers Aide		Education	1		
ğ	es 1 and 2 should be titer of Health and Mental Hyg f Item 27 is marked othe ir other treumatic event,		17. Father's Name (First, Middle, Last)			's Name (First, Middle, M	Maiden Sumame)			
Maryland 21215-0036			Mechack Conway Carrie Brooks							
			19a. Informant's Name/Relationship (Type, Print) Dianna Moses/Daughter		Addison Rd. #					
Baltimore,			20a. Method of Disposition 1 □ Surial 2 □ Cremation 3 □ Removal from State	Place of Dispo	sition (Name of natory or other place)	Date	20c. Location - City or Tox	wn, State		
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Bal	permit. Pag Depertment Important: I eny injury o		22. Name and Address of Facility H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019							
H	Physician /Medical Examiner		23a. Part1. Enter the disease, or complications that caused the deat shock, or heart failure. List only one cause on each line.					Approximate Interval Between		
			Immediate Cause (Final disease or condition A Civil Reshiputor Paylore Paylore							
1			resulting in death)  Due to (or as a consequence of):							
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P.0	that the ed by detac		Part II. Other significant conditions contributing to death but not res	ulting in the u	nderlying cause given in Part I.	23e. Did tob	pacco use contribute to the	e cause of death?		
Vital Records,	To the Hospital or Attending Physicien: The law requires that the death certific within 24 hours after death.  To the Funeral Director: Atter this certificate has been signed by the attending I completely filled in by the funeral director, page 2 should be detached for use as					1 □ Ye	es 2 □ No 3 □ Proba	ably 4 □Unknown		
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1 0			27. Manner of Death 28a. Date of Injury (Month, Day Year)	28c. Injury at Work?	28d. Describe how injury occurred					
<u>ō</u>			2 Accident investigation	M 1 Yes 2 N	О					
Division			3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, building, etc. (Specify)		eet, factory, office	ctory, office  28f. Location (Street and Number or Rural Route Number, City or Town, State)				
_		Medical C	29a. Certifier  (Check only   Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
		Med	one) and manner stated.  29b. Signature and title of certifier , 29c. License number 29d. Date signed (Month, Day, Year)							
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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  209  TA thin A 16 Att MED 1 MD 831 (INVERSITY RIVE) 511/458, 588 NO.										
	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  The liminary of the All All All MED, and \$31 UNIVERSITY BIVE SILVER SIRING, Md.,  State Registrar  31. Date filed (Month, Day, Year)  32. Registrar's Signature									
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# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			State of Maryland / Department of Healt Certificate of Deat			erie 200	6 23033			
			1. Decedent's Name (First, Middle, Last)	2.	Dete of Deeth Month	n Day Year	3. Time of Death			
4	Physici /Medio		DENNIS BLACK MATHEWS		July 2	•	4:00 pm			
	Examir		4a Facility Neme (If not institution, give street end number)  4b. City,	y, Town, or Locati	ion of Death	4c. County of De	eth			
				Bethesda		Montge				
	Funeral		Months Days Hour	urs Min.	Date of Birth (Month, Day,	Year) 9. B	irthplace (State or Foreign Country)			
	Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  Important: If them 27 is marked other than "natural", or thams 23a or 28a-4 show any injury or other traumatic event, the Medical Examiner must be notified at once.	To Be Completed by Funeral Director	578-68-4058 53 Yrs.		Sept. 2	27, 1952	Vashington, DO			
5			Usuel Residence of Decedent  10e. State 10b. County 10c. City, Town or Location				10d. Inside City Limits			
a Van							1⊠Yes 2□No			
9			D.C. Washington, D.C.  10e. Street end Number 10f. Zip Code		10	og. Citizen of What C	Country?			
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4			403 Quackenbos St., NE 20011  11. Marital Status 12. Wes Decedent Ever in U.S. 13. Was Decedent of Hispanic	c Origin? (Specifi	v Yes or No-	U.S.A.	nerican Indian,			
Į,	The Part		11. Marital Status  12. Wes Decedent Ever in U,S. Armed Forces?  1 ☑ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No	xicen, Puerto Ric	an, etc.)	Black, Wh				
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ב ב	ked o		Thomas Alton Mathews	Va	Vanese Barker					
מיש	N pu		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Nur	umber or Rural R	al Route Number, City or Town, Stete, Zip Code)					
2 5	27 le		Lydia Mathews - Sister 403 Quackenbos	St. NE	Wash	ington, DO	20011			
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Baltimore, maryland 21215-0020	orta Inju		21. Signal re of Euneral Service Livensee 22. Name and Address of Fa	acility Gascl	h's Fur	neral Home	P.A.			
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S S	pe de de de	Ą	HISKOY OF HOLF WOOD FOUN		24a. Was en autopsy performed?  24b. Were autopsy findings available prior to completion of cause of death?					
DIVISION OF VITAI RECORDS, P.O. BOX	en si ould	8	History of Received Sippin.							
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	er de	# E	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Plece of Injury · At home, farm, street, factory, office building, etc. (Specify)				3f. Location (Street and Number or Rural Route Number, City or Town, Stete)			
בֿ בֿ	e of in	Certification: To								
9	To the propriet of Authoring Propercient: The law requires that the locality can be executed within 24 hours after death.  To the Funeral Director: After this cartificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the bunal-transit	edicai	29a. Certifier (Check only (Check only 2) Medical Examiner: On the basis of exemination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
1		8	one) end manner stated.							
Š	Z F E	Σ	29b. Signature and title of certifier  29c. License numb			9d. Date signed (Mo	nin, Dey, Yeer)			
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)	(6)		30. Name end address of person who completed cause of death (Item 23e) (Type, Print)							
1	(6)		30. Name end address of person who completed cause of death (Item 23e) (Type, Print)  Suhi Ha Bhogavi V., 1220 A Earl Toppa Road, Ficik 230, Towson, Tr. D 21286.  31. Date filed (Month, Day, Year)  32. Registrar's Signature  JUL 0 6 2006							
	Sta		31. Date filed (Month, Day, Year)  32. Registrar's Signature		,	-				
	Regist	rar	JUL U O LUUD JURAN A JURAN							

DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene ? 1 - State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** June 26, 2006 HERMAN MCNEIL 6:50pm /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner **SUBURBAN** HOSPITAL Bethesda Montgomery If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Months 1 **X** M 2 □ F 73 July 18,1932 Director South Carolina 240-40-2374 Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a State r 28a-f ehow 1X Yes 2 No Directo Washington D.C. 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code r than "natural", or items 23a or tre Medical Examinar must be U.S.A. 20018 1812 Newton St., N.E. Funeral within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1X Yes 2 □ No If Yes, Give 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: Specify: Black þ 3 Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Privat<sub>e</sub> 2yrs Unknwon 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Mental is marked Kathern McCall James McNeil 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) and 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 sh Department of Health and Important: If Item 27 is m eny injury or other traum QDCs. 1812 Newton St., N.E. WDC 20018 Kimberly Trent/Cousin 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 🛣 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Harmony Memorial Pk 6/30/06 Landover, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Johnson & Jenkins Inc. 716 Kennedy St., N.W. Wash. D.C. 20011 23a. Part / Enter the dikease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CHRONIC OBSTRUCTIVE PULMONARY DISEASE /Medical Due to (or as a consequence of): GRAM NEGATIVE ROD BACTEREMIA Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): burial-transit NOSOCOMIAL PNEUMONIA Exami that initiated events resulting in death) Last Due to (or as a consequence of): physician streets the burial 68760, Physician/Medical attending | Box ( IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4 Pregnant at time of death 5 Other (specify) P.O. been signed by the should be detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Retroperitoneal Hematoma 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 🛣 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an Pulmonary Emboli s certificete has t lirector, page 2 s autopsy performed? 1 Yes 2 No After this certification funeral director. Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 I Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No ٩ 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation illed in by the fu 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Ptace of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after of To the Funeral Direct 4 Homicide 1st Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29d. Qate signed (Month, Day, Year) 29c. License number and title of certifier 29b. Signatura D0061302 06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 9901 Medical Center Drive, Rockville, Md. 20854 Atul Rohatgi, M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 5 2006 Registrar

McNeil

State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 5:45 July 4, 2006 Mary Ann Moore /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Annapolis Anne Arundel Anne Arundel Medical Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea 5/18/1932 Birthplace (State or Foreign
Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1□M 2**X**F Days Hours Yrs. 74 Pennsylvania 205-24-2363 Director Usual Residence of Decedent death with the Maryland 10d Inside City Limits 10a State 10b. County 10c, City, Town or Location in than "natural", or itsms 23a or 28e-1 show the Mudical Examinar must be notified at 1 ☐ Yes 2 X No Anne Arundel Annapolis Maryland Directo 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21401 USA 2555 Jigger Way 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. Int: If item 27 is marked other than "natural", or its 1 Never Married 2X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: White þ 3 ☐ Widowed 4 ☐ Divorced Completed 16b Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12th Homemaker **Home** or other traumatic avant, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Frances Straitiff Joseph Berg, Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) William R. Moore/ Husband 2555 Jigger Way, Annapolis, Maryland 21401 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Discosition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) permit. Page Depertment o importent: if any injury or once. 7-5-06 Edgewater, MD Kalas Crematory 21. Signature du ver Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** Van SMalle la montres lung concer disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 Ectopic pregnancy Month Day Year signed by the et id be detached to 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknows Part If, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown Yes 2 🗆 No should 24a. Was an autopsy periol m 24b. Were autopsy findings available prior to completion of cause of death? s certificate has t director, page 2 s 2 No 1 Yes No 1 TYes To the Hospitel or Attending Physicien: director, Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Inpatient Other: 1 🗌 Yes 2 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ After thi funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Deat 28b. Time of 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No death. I Director: A id in by the fu investigation 6 ☐ Could not be 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after To the Funerel Dire 4 Homicide 29a. Certifier Certifying Physician: To the bast of my knowledge, death occurred at the time, date and plane, and due to the name(s) and manner as stated Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier Clening Were My death (Item 23a) (Type, Print)

900 BOSt get Coad#300 Anapolis MDZ1401 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) leavine werner 31. Date filed (Month, Day, Year) 32. Segistrar's Signature State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 🤈 🖺 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day 2006 Year **Physician** July 6, 0315 James Foxx Myers /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Carroll Carroll Hospital Center Westminster | If Under 1 Year | If Under 24 Hrs. | Nonths | Days | Hours | Min. | May 17, 1933 5. Social Security Number Birthplace (State or Foreign Country) 6 Sex 7. Age (In vrs. last birthday) **Funeral** 1 M 2□ F Yrs. 73 Director Maryland 219-78-1763 Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or items 23a or 28a-f ehow the Medical Exeminer must be notified at Carroll Union Bridge 1 Yes 2 No Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 East Locust Street 21791 USA Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ₩ Never Married 2 Married 1 ☐ Yes 2 No If Yes, Give Year or Dates: 0. Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: white Š 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7 th and Mental Hygiene. N/A Elementary/Secondary (0-12) College (1-4or 5+) N/A N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Benjamin William Myers, Sr. Vallie Pauline Heiner 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) s 1 and 2 s of Health an Itam 27 is 893 Banner Ave, Union Bridge, MD 21791 John T. Myers, brother 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition permit. Pages 1
Department of H
Important: if Ital
any Injury or oth 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Pleasant Valley Cem. 07/08/2006 Westminster, MD 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Signature of Funeral Service Licenses M01191 91 Willis Street, Westminster, MD 21157 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner NEUMONIA Sequentially list conditions, If any, Judoing to in mediate cause. Enter Underlying Cause (Disease or injury that initiated events physicien end s the burial-transit certificate be executed resulting in death) Last Due to (or as a consequence of): Physician/Medical as attending p 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Month Day 4☐ Pregnant at time of death signed by the at d be detached fo 5 Other (specify) o 9 Unknown 9 Unknown ے Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Hinknown this certificate has been si al director, page 2 should 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? MENTAL RETARDATION 1 Yes 1 ☐ Yes 2 ☐ No 2010 of Vital ospital or Attending Physician: I hours after death. uneral Director: After this certifical y filled in by the funeral director, p 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 10 HO 2 ER/Outpatient 3 DOA Certification: 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide To the Hospital o within 24 hours af To the Funeral D completely filled in 29a. Certifier 1 🕒 certitying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29b. Signature and M.P. D0054580 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Balt St # WODIM 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 0 7 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death Month Year **Physician** 200 avon /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Cecil N. Lockwood Road Elkton 5. Social Security Number If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) **Funeral** 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 1 □ M 2 T F Months Days Hours Min. Yrs. 146-36-3608 Director 61 21. Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits item 27 is marked other then "neturel", or items 23a or 28e-f show other treumetic event, the Mydical Examination ust be multiled at 1 Yes 2 No Director MD Elkton Cecil 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 48 N. Lockwood Road 21921 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after inent of Health and Mental Hygiene. ont: If item 27 is marked other then "neturel", or Ite 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: 3 ☐ Widowed 4 ☑ Divorced White. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 Accountant Accounting 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be John T. Riley Alma L. Prosper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1816 Dellabrooke Farm Lane, Brookeville, MD 20853 James Milne/son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 07-10-2006 ÷ 5 Department of Importent: If any injury or once. ' 4 ☐ Donation 5 ☐ Other (Specify) R.T. Foard Funeral Home, P.A. Rising Sun, Maryland 22. Name and Address of Facility R.T. Foard Funeral Home, P.A. 21. Simur of Funera Service L 21915 318 George St., Chesapeake City, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician avia disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner Hospitel or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death 23b. Was decedent pregnaps 23d. Date of delivery 3 Ectopic pregnancy in the past 12 mon Day 4☐ Pregnant at time of death 5 Other (specify) P.O. detached Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death Check on one examiner' Other: 4 Nursing Home 5 Sidence 6 Other (Specify) Certification: To 1 Tyes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Death 28b. Time of 28d. Describe how injury occurred 1 Shintural 5 Pending death. investigation 1 ☐ Yes 2 ☐ No 2 Accident after death Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 24 hours a Funerel 6 29a. Certifier Medical Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely (Check only within 2 the

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> State Registrar

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Name and address of person who completed cause of death (Item 23a)

Signatur

32. Registrar's Signature

29c. License number

29d. Date signed (Month, Day, Year)

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1 Decedent's Name (First Middle, Last) 3. Time of Death **Physician** ALFRED VERNON MCNEAL 9:00AM " JULY 2006 /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 9818 OCEAN GATEWAY TALBOT EASTON If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Months Days Hours Min. SEPT 2, 1924 5. Social Security Number 7. Age (In vrs. last birthday) 9. Birthplace (State or Foreign Sex X M 2□F **Funeral** Months MARYLAND 81 Vrs 214-30-8441 Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10c. City. Town or Location 10a State 10b. County r than "natural", or Items 23a or 28a-f show the Medical Examinar must be notified at 1 Yes 2 No Director MD TALBOT EASTON 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 9818 OCEAN GATEWAY or Items 23a 21601 TISA death Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian 11. Marital Status Black, White, etc. it. Pages 1 and 2 should be filed within 72 hours after intent of Health and Menial Hygiene.
riant: If item 27 is marked other than "natural", or ite njury or other traumatic event, the Medical Examina. 1 Never Married 2 Married Baltimore. Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: WHITE ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education 16a. Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) MAINTENANCE MECHANIC PETROLEUM DISTRIBUTOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be CARROLL COOKMAN MCNEAL IDA MAE HALL ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 9818 OCEAN GATEWAY, EASTON, MD 21601 SHIRLEY L. MCNEAL/WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State LANDING NECK CEMETERY 7/7/2006 4 ☐ Donation 5 ☐ Other (Specify) TRAPPE, MARYLAND permit.
Departn
Imports
any nju 21. Signature of Funeral Service Licensee 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST EASTON, MD 21601 JOHNR, MERCEROI 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) cardiorespiratory Physician 5mn-123 /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, flany, leading to infraediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The taw requires that the death certificate be executed ig physician and as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical attending esn 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ō Dav in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No ed by the a 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 9 1 ☐ Yes 2 ☐ No 3 Probably 4 □Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy perform, 1 ☐ Yes 2 ☐ No after death.

Director: After this certific: Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 ☐ Yes No Hospital: Other: 4 Nursing Home X Residence 6 Other (Specify) P 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death Natural 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification; 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 6 □ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a Certifier completely and manner stated To the I within 2 To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Dav. Year) D 3664 106 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) -60-CAS 70W CAM 21607 509 IDKWI WAVE ASJANAT EMM UNOU 2. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 0 3 2006 Registrar

1 - For Stete Registrer

1. Decedent's Name (First, Middle, Last)

Certificate of Death

2. Date of Death

3. Time of Death

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		ns 23e	era	11. Marital Status	KRAT C		12. Was Dece	edent E	ver in U.S	S. 13. V	Was Decede			igin? (Spe
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	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "neturel", or Items 23e or 28e-1 show eny Injury or other treumatic event, I'm Medical Examiner must be rediffied at Once.	Completed by Funeral Director	Elementary/Second 12	ondary (0-12)		College (	1-4or 5-	<b>+</b> )		CRETAI		,	
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MARION MARVEI	lar	2 sho and I is me		19a. Informant's N						4	ng Address (			
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AR.	Ë	t. Pa rtmen rtent: njury		° 4 ☐ Donation					CED		L CEM			7/6/2
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				23a. Part1. Enter	the disease, d	or compli	cations that of	caused	the death					
		Dhysisian		shock, or hea	art failure. Lis (Final	st only or	e cause on e	each lin	θ.		106			116
		Physician /Medical		disease or condition resulting in death)	on	•			consequ		101-		017	
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		n =	ner	Sequentially list or if any, leading to it cause. Enter Und Cause (Disease or	ongitions, mmediate erlying	,		(or as a	consequ	ence of):				
		aw requires that the death certificate be executed is been signed by the attending physician and 2 should be detached for use as the burial-transit	pleted by Physician/Medical Examiner	Cause (Disease or that initiated event resulting in death)	S	•	. Due to	(05.00.0		2222 26):				
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	ecords, P.O. Box 68760,	physi s the	dle				1							
	×	certif nding use a	N/Me	IF FEMALE: 23b. Was deceder	nt pregnant	2	3c. If yes, ou	tcome o	of pregnar		-			
	Ď.	death e atte d for	icia	in the past 12	2 months?		4□Pregr	nant at	2 □ Fetal time of de		Ectopic pred Other (spec			
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	S, F	es tha gned be de	by P	Part II. Other sign	ificant condit	ions cor	tributing to d	eath bu	t not resu	tting in the u	nderlying car	use give	n in Part I	•
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	Division of Vital Ro	or Attending Physicien: The iffer death. Director: After this certificate him by the funeral director, page	tlon	1 Natural 2 Accident	5 🗌 Pend	ing tigation	(Mon	th, Day	Year)	Injury	м	c. Injury Work 1 🔲 ۱	(? ∕es 2 🗍	
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	Ö	after	Serti	4 🗍 Homicide			build	ing, etc	. (Specify	)				
		To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director: After this certifical completely filled in by the funeral director.	Medical Certification;	29a. Certifier (Check only			sicien: To the							
		the H nin 24 the F nplete	Medi	one)			and man							
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		18		30. Name and add							E, EAS	ION.	MD	21601
		Sta	ate	31. Date filed (Mo					r's Signat					

JULY Day **2 Physician** 2006 10:15AM<sup>™</sup> MARION GISCHEL MARVEL /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) **Examiner** TALBOT HOSPICE HOUSE EASTON TALBOT 8. Date of Birth 9. Birthplace (State Country)
SEPT. 26, 1918 MARYLAND 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 10d. Inside City Limits Yes 2 No 10g. Citizen of What Country? USA in? (Specify Yes or No-Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry of working STATE HOSPITAL r's Name (First, Middle, Maiden Sumame) BARA KATHRYN RABER r or Rural Route Number, City or Town, State, Zip Code) MD 21612 Date 20c. Location - City or Town, State 7/6/2006 BALTIMORE, MARYLAND BEIN & NEWNAM FUNERAL HOME PA ST EASTON, MD 21601 Approximate Interval Between Onset and Death cardiac or respiratory arrest, clark 11021 23d. Date of delivery Month Year Day 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performe 1 Yes 2 No of Death (Check only one) rsing Home 5 Tesidence 6 Nother (Specify) HOSPICE 28d. Describe how injury occurred No 28f. Location (Street and Number or Rural Route Number, City or Town, State) d place, and due to the cause(s) and manner as stated.
th occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 132 7-3-06

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State

Registrar

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			1 - For State Registrar		State of	of Maryla		•	rtment				lental Hy	Reg. N	1	006	)	231	040
	Physici	an	1. Decedent's Name (First, Mid										2. Date of Do Month	D	ay	Year		3. Time of	
1	/Medio		SHARON LEE  4a. Facility Name (If not institut			ımber)			4b. City, T	own, or	Location of	of Death	JULY	4		2006 unty of Dea		6:20	P ""
	Ladiiii		FREDERICK	MEM	ORIAL	HOSP	ITAL		FREI					F	RE	DERI	СК		
	Funeral Director		5. Social Security Number 219–44–4879	6. Sex	x ]M 2∏gF	7. Age (In y	yrs. last birth	day) rs.	If Under 1 Months	Year Days	If Under Hours	Min.	8. Date of Bi (Month, D April	rth ay, Year 14.1	947	C	ountry,	e (State o ) v1var	-
	pur »		Usual Residence of Decedent 10a. State 10b. Cour	tv		10c.	City, Town	or Loc	cation				•					Inside Ci	
	Maryli -f eho	tor	161	deri	ok		alkers											1 🗌 Yes	
	or 28s	Director	10e. Street and Number	UCLI	CR	, yvc	ZIKELS	V	10f. Zip (	Code				10g. C	itizen	of What C	ountry	?	
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ဖွ	be filed within 72 hours after death with the Maryland that Hygiene. Id other then "natural", or items 23s or 28s-f ehow event, the Medical Examinar mast be notified at	Funeral I	11. Marital Status 1 □ Never Married 2 🔀 M		Armed F	orces? 2 ⊠ No			Yes, specif		Specify:		ecify Yes or N Rican, etc.)			Black, Whi			
21215-0036	hours tural',	ed by	3 Widowed 4 Divorc		Year or [		162 [		ent's Usual					16h		WI of Business	nite		
215	within 72 ene. then "na	Completed	(Specify only high	nest grade	e completed)	) (1-4or 5+)	(	Give I	kind of work OO NOT use	done d	uring mos	t of worki	ng	100.	XIIIO O	n business	viildus	ury	
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Maryland	d be fill antal H ced ott	Be c	17. Father's Name (First, Midd.) William Howard		hr								(First, Middle Pheil	, Maide	n Sun	name)			
ary	s 1 and 2 should be of Health and Mental item 27 ie marked o other treumatic eve	2	19a. Informant's Name/Relation				19b. l	Mailin	g Address (				I Route Numb	er, City	or To	wn, State,	Zip Co	ode)	
	1 and 2 Health a tem 27 ic		William E. Mil	es/	Husban						d. Wa		sville						
Dore			20a. Method of Disposition  1 ☐ Burial 2 ☑ Crematio  4 ☐ Donation 5 ☐ Other				b. Place of E cemetery,	crem	atory or oth	ar place	9)   7		006			on - City or			V1421.
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	Physician /Medical		23a. Part1. Enter the disease, shock, or heart failure. L Immediate Cause (failar disease or condition resulting in death)	or compli	a. A	caused the deach line.  Van Coras a con	ed E	30					r respiratory a	arrest,			Int	oproximate terval Bety nset and D	ween
	Examiner	_	Sequentially list conditions,	ŀ	0							,							
	uted d ansit	Examiner	il any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events	【。		(or as a con	eaquencs of	y:											
8760,	ate be executed hysician and the burial-transit		resulting in death) Last			(or as a con:	sequence of	):											
687	ficate to physics the t	edical			d									-			Y		
P.O. Box	that the death certifice ed by the attending pt detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	2	1 Live	utcome of pre birth 2 IF nant at time on	etal death		Ectopic pre Other (spe						23d.	Date of de Month	livery Da	y Y	⁄ear
	quires that the signed by all did be detacted	by	Part II. Dther significent cond	itions cor	ntributing to c	death but not	resulting in t	the un	derlying ca	use give	n in Part I.				use o	contribute t		ause of d	
Division of Vital Records,	The law requires that the ate has been signed by th page 2 should be detache	Completed					_				, <u>, ,</u>		24a. Was auto perfe 1 Yes	psy ormed?	1	tb. Were a prior to death?	compl	etion of ca	available ause of
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ot	g Phys er this eral dir	n: To	1 ☐ Yes 2 ☑ No 27. Mann of Death		112	Inpatient 2 of Injury oth, Day Year	2 ER/Outp	me of		c. Injury Work	4 🗀 140		ne 5 Res 28d. Describe				ecify)		
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	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funarel Director: After this certificate has completely filled in by the funeral director, page 2	edicai	29a. Certifier 1 Certifier (Check only one) 1 Medic	ying Phys al Examii	ner: On the b	e best of my pasis of exam nner stated.	knowledge, nination and/	death or inv	occurred a estigation, i	t the tim	e, date an inion, dea	d place, a th occurre	and due to the ed at the time,	cause(s	s) and nd plac	l manner a ce, and du	s state e to the	d. e cause(s)	)
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in the	Sta Registi		JUL	1 0 2	006	gistrar's Si	1	4	No.										

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** Patricia Malone 0920 Ann /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner NICOMICO PEN/ASULA MEDICAL CENTER SALLSBURY REGIONAL If Under 1 Year If Under 24 Hrs. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Funeral Davs Hours Min. 1 ☐ M 2**X** F 76 213-24-4248 Director 9/2/1929 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Heelth and Mental Hygiene. Important: if item 27 is marked other than "naturel", or tieme 23a or 28e-f show any injury or other traumatic event, if a Medical Examinar must be notified at once. 1 X Yes 2 □ No Wicomico Salisbury Maryland Directo 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21804 202 Woodcrest Ave. USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes No Specify. Specify: white Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Sales Clerk Retail Clothing Store 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Cohee Eunity Cooper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 202 Woodcrest Ave., Salisbury, MD 21804 William F. Malone/husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/7/06 Parsons Cemetery 4 □ Donation 5 □ Other (Specify) Salisbury, MD 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Home Professional Association 501 Snow Hill Rd., Salisbury, MD 21804 Part 1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. no not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final End Stage COPD **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine the ettending physicien and hed for use as the burial-transit death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 2 Fetal death 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) page 2 should be detached 9 Unknown 9 Unknown has been signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by and 1 Yes 2 No 3 Probably 4 Unknown Cancer PREUMORECTOM 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform this certificate 2□No 1 ☐ Yes 2 No 1 Tes or Attending Physicien: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification; To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred After 1 Natural 5 Pending Injun To the Hospitel or Attending within 24 hours after death.
To the Funeral Director: After completely filled in by the fune. м 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 29a. Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and litte HOO64534 71406 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SACISBURY MD 21801 FELDER 100E CARROLL MICHAEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month **Physician** GAMBLE NELSON MARY 8, 10:30 A M July 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Somerset Crisfield 3 Village Drive - Apt. 15 If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) July 30, 1927 Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) Funeral Months Days Hours 1 ☐ M 2 🖫 F Yrs. West Virginia 78 Director 232-32-5944 Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland . Department of Health and Mental Hygiene. Important: If itam 27 is marked other than "natural" ..... any injury or other traumatic avantance. 10a State 10h County 10c. City. Town or Location 10d. Inside City Limits Crisfield Maryland Somerset 1X Yes 2 □ No Director 10g. Citizen of What Country? 10f Zin Code 10e. Street and Number 21817 U.S.A. 3 Village Drive - Apt. 15 Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Specify: White 1 ☐ Yes 2 No Specify: þ 3 Nidowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Medica1 File Clerk 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Leona Gay Badgett Kennà Lee Keaton 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Doris Kay Deane (Daughter) 1942 Holborn Road - Baltimore, MD 21222 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 7/8/06 Baltimore, MD MD ANATOMY BOARD 4 Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Bradshaw & Sons Funeral Home 306 W. Main St.- Crisfield, MD 21. Signature of Funeral Service Licenses 1. 166 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** CANCER LUNG /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical as the t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Ses 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performe 1 Yes 2 No 2 No 1 Yes or Attending Physician: funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 2 **N**O 1 Inpatient 2 ER/Outpatient 3 DOA 1 🗌 Yes Certification: To 28b. Time of 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident after death filled in by the 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide within 24 hours a To the Funeral L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title o certifier 7/8/2006 M.1) 00062172 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POLOMOKE CITY MD SATYAL, MD 1604 MARKET ST 21351. SHARAD R 32. Redistrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 0 2006 Registrar

			For			nd / Depa	artment of I	Health a	and Me	•	iene		043
			State Registrar			Ce	rtificate of	Death			g. No.		
	Physici		1. Decedent's Name (First, Middle,							L. Date of Death JMIND 3,		3. Time o 8:16	
	/Medic Examin		Josephine T.  4a. Facility Name (If not institution, g				4b. City, Town, o	or Location of	of Death		4c. County of D	eath	
6"	<u> </u>		Civista Medical				LaPlata		O.4 Men.		Charle		
7	Funeral Director		5. Social Security Number 677-07-6723	.Sex 1 ☐ M 2 🛣 F	7. Age (in yrs. 88	. la <i>st birthd</i> ay) Yrs.	Months Days	If Under Hours	Min.	Date of Birth (Month, Day, 12/13/1		Birthplace (State Country) Lnnesota	
1 -	P		Usual Residence of Decedent  10a, State 10b, County			ity, Town or Lo	nation			12/13/1	717 111	10d. Inside (	
S	after death with the Maryland or Itams 23a or 28a-f show ment must be notified at	Ď	Maryland Charle	C		aldorf	Joanon						s 2⊠No
P	th the	Director	10e. Street and Number	.5	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ardorr	10f. Zip Code			10	og. Citizen of What	Country?	
2	s 23a	rai	3006 Lovelace Co		1 5 . 1 . 1	10	2060				U.S.A		
2,2	fter de r Itam inern	Funeral	<ul><li>11. Marital Status</li><li>1   Never Married 2   Married</li></ul>	12. Was Dece Armed For 1 ☐ Yes	rces? 2 <b>X</b> No		Was Decedent of I			can, etc.)	Black, W		
Spe	72 hours a natural', o dical Exan	d by	3 Widowed 4 Divorced	If Yes, Giv Year or Da			1 ☐ Yes 20K No		i 		Specify:Wh		
15.0	s within 72 hours after death with the Marylan liene. r than "natural", or Itams 23s or 28a-f show the Medical Examiner must be notified at	Be Completed by	15. Decedent's (Specify only highest	grade completed)		16a. Dece (Give	dent's Usual Occuj kind of work done DO NOT use retire	pation during mos d)	st of working	, 1	16b. Kind of Busine	ss/Industry	
25.5	d within giene. er than	Som	Elementary/Secondary (0-12)	College (1	-4or 5+)		strative				Veterans	Admin.	
and but	be filed ntal Hyg ad other avant.	Be (	17. Father's Name (First, Middle, La								faiden Surname)		
2 Signal	2 should be f and Mental h Is markad or aumatic ava	2	Santo Pennestr  19a. Informant's Name/Relationship			19b. Maili	ng Address (Street			Sgro Route Number,	City or Town, State	e, Zip Code)	
D. ∑E	nit. Pages 1 and 2 should be filed artment of Health and Mental Hyg ortant: If itam 27 Is markad othe injury or othar traumatic avant.		JoAnn McWilliams			20416	Rivervi	ew Dr			Coltons		D20626
S	Pages 1 and of He sut: If itan		20a. Method of Disposition 1 ★Burial 2 ☐ Cremation 3	☐Removal from S	olale i		osition (Name of matory or other pla		Dat		20c. Location - City		
	permit. Page Department Important: If any injury o		*4 □Donation 5 □ Other (Spe 21. Signature of Funeral Service Lie		For		oln Ceme  Name and Addre				Brentwood	, MD	
B A	Depa Impo any it		Man Y. 1	libe							п г.п. ood, MD 2	0722	
			23a Part1. Enter the disease, or conshock, or heart failure. List or	mplications that cally one cause on e	aused the dea							Approxima Interval Be Onset and	etween
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		mone	i					Oriset and	Death
	Examiner			Due to (	or as a conse	quence of):							
	p #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (	or as a conse	quence of):							
•	be executed sician and burial-transit	Examiner	that initiated events resulting in death) Last	c	or as a conse	quence of):							
760,	m 5 m	calE		d									
68	h certificat ending phy use as th	Medi	IF FEMALE:	00-11									
Вох	To the Hospital or Attanding Physician: The law requires that the death certifica within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phoompietely tilled in by the funeral director, page 2 should be detached for use as it	by Physician/Med	23b. Was decedent pregnant in the past 12 months?		come of pregn irth 2□Fet ant at time of	al death 3[	⊒Ectopic pregnanc ⊒ Other (specify)	у			23d. Date of Month	,	Year
P.O.	that the death	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□Unkno			1.7 . 7/ =						
<u>8</u>	res tha igned be de		Part II. Other significant condition	s contributing to de	eath but not re	sulting in the u	nderlying cause gr	ven in Part I	I.		acco use contribute	to the cause of Probably 4	- 1
of Vital Records,	w requir been si should	Completed						-		24a. Was an		autopsy findings	
Re	The lav ate has page 2	ошо								autopsy	prior to death	to completion of	
/ital	ysician: Th is certificate director, pag	BeC	25. Was case referred to medical examiner?							Check only one	3)		
of	Physi r this c ral dire	은	1 Yes 2 No 27. Manner of Death			ER/Outpatier					nce 6 Other (S	pecify)	
ion	ttending Ph death. ctor: After th y the funeral	ation	1   Natural 5 □ Pending 2 □ Accident investiga		of Injury h, Day Year)	Injury	Wo	rk? Yes 2□			,.,		
Division	or Attenction for the death inector:	Certification;	3 Suicide 6 Could no 4 Homicide determin	ed 286 Place	of Injury - At h	nome, farm, st ify)	reet, factory, office		28	f. Location (Str. City or Town,	eet and Number or , State)	Rural Route Nur	nber,
Ω	To the Hospital or Attenwithin 24 hours after deal To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying	Physician: To the	best of my kn	owledge, deat	h occurred at the ti	me, date an	nd place, and	d due to the ca	use(s) and manner	as stated	
	n 24 h n 24 h ha Fur ofetely	edical	(Check only 2 Medical Ex	aminer: On the ba	sis of examin er stated.	ation and/or in	vestigation, in my	opinion, dea	ath occurred	at the time, da	ite and place, and o	lue to the cause(	s)
	To the To the Comp	ž	29b. Signature and title of certifier	Mathi			29c. Licens			29	od. Date signed (Mo	onth, Day, Year)	
	(1)		30. Name and address of person w	no completed caus	e of death /Ite	m 23a) (Type	D-52:	20 <del>9</del>			7/3	156	
CIR	(5)		Nalin Mathur, MD	, 10 St.	Patric	ks Dr.	, Suite	404, N	Valdor	f, MD	20603		
:	Sta		31. Date filed (Month, Day, Year)	32. R		ature form							
	Registi	ar	JUL 0 5 200	O process		1							

Thomas A. Plunkard

#### Please Type or Print in Black Indelible Ink

i lease Type	of 1 fills in Black machine i.i
State of Maryland / De	partment of Health and Mental Hygiene

		1- For State Certificate of Death Registrar		No. 2006 2304
Physicia Medical Examir	n/	1. Decedent's Name (First, Middle,Last) Thomas Aaron Plunkard	June 29, 20	Day Year 1530 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Bank of Little Pipe Creek  Keymar		4c. County of Death Frederick
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	_	n(MM/DD/YYYY) 9 Birthplace (State or Foreign
Director		220-29-0161 1XM 2F 16 Yrs. Months Days Hours Min.	Nov. 2	24,1989 Country) Iceland
ý	F	Usual Residence of Decedent  10a State 10b County 10c. City, Town or Location	-	10d Inside City Limits
d now any		Maryland Frederick Keymar		1 Yes 2 XNo
daryland 28a-f show 1 at once.	ま	10e. Street and Number 10f Zip Code	10	g Citizen of What Country?
th the Ma 23a or 22 motified	Director	12203 Warner Rd. 21757		U.S.A.
n with	eral	11 Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Sp. 14 November 1997)  14. Was Decedent of Hispanic Origin? (Sp. 15 November 1997)  15. Was Decedent of Hispanic Origin? (Sp. 15 November 1997)  16. Was Decedent of Hispanic Origin? (Sp. 15 November 1997)  17. Was Decedent of Hispanic Origin? (Sp. 15 November 1997)  18. Was Decedent of Hispanic Origin? (Sp. 15 November 1997)  19. Was Decedent of Hispanic Origin? (Sp. 15		14. Race - American Indian, Black, White, etc.
more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland net of Health and Mental Hygiene unt: If item 27 is marked other than "natural", or items 23a or 28a-f she other traumatic event, the Medical Examiner must be notified at once	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No 1 3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:	,	Specify White
urs afte tural"	<u>و</u>	15. Decedent's Education (Specify only highest grade completed)  16a Decedent's Usual Occupation (Give kind of v		16b. Kind of Business/Industry
72 hor	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life DO NOT use reti	red)	
5-0036 Iled within 7 Hygiene I other than the Medica	d L	11 student  17. Father's Name (First, Middle, Last) 18. Mother's Name	(First Middle M	high school
e, MD 21215-00.  I and 2 should be filed with Health and Mental Hygiene item 27 is marked other it rraumatic event, the Mee	Be C	77. I differ o Harris (1 mars) 222-1	imberly	
2121 ould be fill I Mental H s marked ic event,		19a Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or F	Rural Route Numb	per, City or Town, State, Zip Code)
MD d 2 sho lth and n 27 is			eymar, M	1D 21757 20c Location - City or Town, State
Baltimore, MD 21215-0036  vernit. Pages I and 2 should be filed within 72 hours. Department of Health and Mental Hygiene Important: If item 27 is marked other than "naturinjury or other traumatic event, the Medical Exami	1	20a Method of Disposition  1 X Burial 2 Cremation 3 Removal from State crematory or other place)		
timent reant:	d	4 Donation 5 Other Specify Pleasant View Cemetery 7/ 21 Signature of Funeral Service Licensee 22. Name and Address of Facility Ha		
Baltimore permit. Pages I Department of F Important: If injury or other				oro, MD 21798
Physician		23a. Part I. Enter the disease, or complications that sused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory arre	st, shock, or heart Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease a Drowning		Death
.xammor		or condition resulting in death)  Due to (or as a consequence of):		
	Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	_	
	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):		
50, te be executed ysician and hurial - transit	Ĕ	d		
Box 68760, death certificate be executed he attending physician and of for use as the hurial - transi	/Medical	UNPENDED AMENDED		
376( ificate ng phy:		IF FEMALE: 23b. Was decedent pregnant in the part 11 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancy	23d. Date of delivery  Month Day Year
x 68 th cert ttendir r use a	icia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)  1 Yes 2 No 9 Unknown 9 Unknown		
. <b>Bo</b> the dea y the a	Physiciar	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tot	bacco use contribute to the cause of death?
tal Records, P.O. Box 68' rian: The law requires that the death certif certificate has been signed by the attending ector, page 2 should be detached for use as	þ		1 Yes	2 No 3 Probably 4 Unknown
rds, require been si	etec	"	24a Was a	
eco he law ite has	Completed		perform	med? death?
Vital Recc ysician: The lav his certificate ha director, page 2	a)	25. Was case referred to medical 26. Place of Death (Check	only one)	
Vit; Physici	To B	1 V Yes 2 No	,	Residence 6 Other: Scene
Division of Vital Records, P.O. Box 68760, pital or Attending Physician: The law requires that the death certificate by ours after deeper or the this certificate by teral Director: After this certificate has been signed by the attending physic filled in by the funeral director, page 2 should be detached for use as the hun		27. Manner of Death 1 Natural 5 Pending Pending Pending 28a Date of Injury 28b Time of Injury 28b Time of Injury 28c Injury at Work?  1 Natural 5 Pending FOUND: 1 Yes 2 ✓ No	Deceased di	
iSiO - Attener deat	icat	Accident Investigation Jun 29, 2006 1530 hrs  Suicide 6 Could not be 6 Could not be		treet and Number or Rural Route Number, City
Divis	Certification:	Suicide 6 Could not be determined (Specify) Creek	or Town, St Bank of Little	e Pipe Creek, Keymar, Md.
Hos 24 h Fun rtely			d due to the cause at the time, date a	e(s) and manner as started. and place, and due to the cause(s)
To the within To the comple	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated  29b. Signature and fitte of certifier  29c License number		29d Date signed (Month, Day, Year)
•	_	O.C.M.E.		June 30, 2006
190	0	30. Name and address of person who completed gause of death (Item 23a)		
9	5.5	Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21	1201	
S Regis	tate	1 1 1 0 0 100C   177/-4 /X #148/4/C/		
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			1 - For State Registrar	State of Ma	ryland	/ Depa	rtment	of H	ealth a	and M	ental Hy	giene Rag. No.	2000	3 23045	5
	Physici		1. Decedent's Name (First, Middle, Last)	Swevs							2. Date of De Month		Year	3. Time of Death	
	/Medic Examir		4a. Facility Name (If not institution, give s.			) 1	4b. City,	Town, or	Location o	of Death	01_	4c.	County of De	ath	_
	LXumii		Calvert Memi	orial t	(050)	tal	Pri	MG	S FV	ode	rick		Calv	ert	
	Funeral		5. Social Security Number 6. Sex	7. Age		st birthday)	If Under Months	1 Year Days	If Under	Min.	8. Date of Bit (Month, Da	y, Year)	9. Bi	rthplace (State or Foreign Country)	7
Ļ	Director		Usual Residence of Decedent	W 2 7	56	Yrs.					Jan. 7	19	50 Was	hington DC	_
riand	Mo to		10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits	_
Man	ified	tor	Maryland Calvert			Lus	bv							1 ☐ Yes 2X☐ No	,
th the	or 28 g not	Funeral Directo	10e. Street and Number	· · · · · · · · · · · · · · · · · · ·			10f. Zip	Code				10g. Citi	zen of What C	Country?	
ath w	23a	ral	12151 Bonanza Trail					2065					J.S.A.		
er de	Items Dar n	nne		Was Decedent Every Armed Forces?		. 13. V	Vas Deced f Yes, spec	ent of His ify Cubar	spanic Ori n, Mexican	gin? (Spe n, Puerto F	cify Yes or No lican, etc.)	-	<ol> <li>Race - Am Black, Wh</li> </ol>		
ours aft	9	by F	1 X Never Married 2  Married 3  Widowed 4  Divorced	1 ☐ Yes 2 X No If Yes, Give Year or Dates:	,	1	☐ Yes 2	X No	Specify:				Specify: W	Mite	
IIIU Z I Z I 2-0000 be filed within 72 hours after death with the Maryland	ical E	ted	15. Decedent's Educ			16a. Deced	lent's Usua kind of wor	Occupa	ition	A 6	_	16b. Ki	nd of Busines		
thin 7	Med "r	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+	)	life. L	OO NOT us	e retired)	uring mosi	t of workin	9	_	rles Co	•	
w pel	her th		12			Inspe	ctor	1	40 14-45-	N	/F: 14:4-11-		rnment		
i be fi	ed ot	Be	17. Father's Name (First, Middle, Last)  Archie R. Powers								(First, Middle		Sumame)		
should	and Mental Hygiene. Is marked other than "natural", or Items 23e or 28a-f show aumatic event, the Medical Examinar must be notified at	2	19a. Informant's Name/Relationship (Typ	ne. Print)		19b. Mailin	a Address	(Street a			Barl		r Town, State,	Zin Code)	-
and 2	27 is r trau		Zylphia L. Barnes/	Mother									ginia,		
s - 5	item item		20a. Method of Disposition			ce of Dispos					ate		cation - City o		
Dalitimor			1 ☐ Burial 2 ※ Cremation 3 ☐ Re  '4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	1	t Cre				uly 6	, 200	h	la 1 dorf	, Maryland	
Permit.	Depart Import any inj pnce.		21. Signature of Funeral Service Ligense	° M00053		A TORROR	. Name and		embels att			ld W	ashing	ton Road	
u a	OFEG		Mark Allan	Shaw			ntt F						arylan	d 20604	
			23a. Part1 Enter the disease, or complic shock, or heart failure. List only one Immediate Cause (Final	e cause on each line	ne death.	Do not ente	er the mode	of dying	j, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death	
	iysician Medical	1	disease or condition resulting in death)	Due to (or as a	conseque	EVICE	ex_							145	
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ficate	physis the	edical	d.												
Centi	anding use a	n/M	IF FEMALE: 23b. Was decedent pregnant	ic. If yes, outcome of			IT-4i					2	23d. Date of de	alivery	
death	ne atte	Physician/Med	in the past 12 months? 1 \( \sum \) Yes \( 2 \sum \) No	4☐Pregnant at ti			Ectopic pre Other (spe						Month	Day Year	
rat the	d by the	Phy	9 Unknown  Part II. Other significant conditions confi			in = in the			n in Dant I		and Dist			as the serves of death?	
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he la	certificate has rector, page 2	Completed									auto	sy rmed2	prior to death?	completion of cause of	
lan:	leath. tor: After this certificate has the funeral director, page 2	a	25. Was case referred to medical				<del></del>		26. Place	of Death	1 ☐ Yes (Check only o	2 No	1 ☐ Ye	s 2. Mo	
ysici	this cer al direc	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital:	2 🗆 EF	NOutpatient	3 DO	A Othe	r.				0 □Other (Spe	acify)	
dingP	h. After th funeral		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury (Month, Day	Year) 2	8b. Time of Injury	28	Bc. Injury Work	at ?	2	3d. Describe	now injury	occurred /		
tendi	leath. tor: A the fa	cati	2 ☐ Accident investigation 3 ☐ Suicide 6 ☐ Could not be				M		′es 2□ľ						
or At	Direc Direc in by	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	y - At hom (Specify)	e, farm, stre	eet, factory,	office		2	City or To	street and vn, State,	d Number or H	lural Route Number,	
To the Hospital or Attending Physician:	within 24 hours after death. To the Funeral Director: A completely filled in by the fu		29a. Certifier 1 Certifying Physi	lician: To the best of	my knowle	edge, death	occurred a	at the time	e, date an	d place, a	nd due to the	cause(s)	and manner a	s stated.	
he Ho	he Fu	edical	(Check only 2 Medical Examin	er: On the basis of e and manner state	xaminatio	n and/or inv	estigation,	in my op	inion, deat	th occurre	d at the time,	date and	place, and du	e to the cause(s)	
Tot	To t com,	Σ	29b. Signature and title of certifier	11/				License				29d. Date	e signed (Mon	th, Day, Year)	
			1 Allen					67	908			0/	1041	00	
SE	112		30. Name and address of person who cor	hpleted cause of dea	ath (Item 2	and the same		6	M	0					
11)[	Sta	te	31. Date filed (Month, Day, Year)	32. Pigistrar		red	111								
	Registr		JUL 1 0 20	106 Alexan	a s	The A	market	•							

Amended, #7, 17, perfor F. D., TCHD, State of Maryland / Department of Health and Mental Hygiene 23045 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 6-429-2008 Year 8:00a M **Physician** Doris H. Pugh /Medical 4a. Facility Name (If not institution, give street and number)
7487 Bozman-Neavitt Rd.P.O.Box
58
5. Social Security Number 6. Sex 7. Age (In yrs, last birthday) 4b. City, Town, or Location of Death 4c. County of Death
Talbot **Examiner** Bozman If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) 2-6-1929 Birthplace (State or Foreign Country) **Funeral** 77 1 □ M 2 💢 F 76 115-18-2839 New York City Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State Md 10b. County 10c. City, Town or Location r than "natural", or Items 23a or 28a-f show the Medical Examinational benedified at Talbot Bozman 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21612 USA 58 7487 Bozman-Neavitt Rd.P.O. Box Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes X☐ No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) retail Store Clerk 12 years or other traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 Is marked othe any injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Harry Clay Zimmer Harry Clay Limmer Frances Howzer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  $7487 \ \ Bozman-Neavitt \ \ Rd.P.O.Box58, Bozman, Md.$ 19a. Informant's Name/Relationship (Type, Print) Stephen J. Pugh (husband) 21612 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Capitol Crematory 6-30-2006 Dover, De. ^ 4 ☐ Donation 5 ☐ Other (Specify) Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any searing temperature cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of): The law requires that the death certificate be executed the attending physician and thed for use as the burial-tran Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗌 Yes 2 **N**O 3 Probably 4 □Unknown Be Completed page 2 should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificete has 1 Yes 2 No 1 ☐ Yes 2 ☐ No or Attending Physician: hours after death. uneral Director: After this certific ly filled in by the funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Certification: To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only 29b. Signature and title of certifier 29c. License number 29d. Date sigged (Month, Day, Year) 29 06 who completed cause of death (Item 23a) (Type, Print) 30. Name and address of person 29466 Pintail Dr. Easton, Md. Smith, MDDavid H. 32. Registrar's Signature 31. Date filed (Month, Day, Year) JUL 0 2 2006 Registrar

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			For State Registrar	State of M	aryland		artmen <i>tificat</i>			ind Me		giene Reg. No	2000	23067
H			Decedent's Name (First, Middle, Last)								2. Date of De	ath		3. Time of Death
	Physicia		IRENE	OTIG	ERS	RI	JTLE	DGE			July	Da T T	2006	4:48 PM
8 3	/Medic Examin		4a. Facility Name (If not institution, give s			750			Location o		0 442	40	. County of Dea	
	Examin	iei	14221 Dove Cre		#203			C	bark	rs .			Baltim	Ore
	Cuparal	-57	5. Social Security Number 6. Sex		je (In yrs. la			1 Year	If Under 2	24 Hrs.	8. Date of Bir	th	9. Bir	hplace (State or Foreign
	Funeral Director		214-28-3192	M 2X F	82	Yrs.	Months	Days	Hours	Min.	11/16	/ Year	23 Pen	nsylvania
	3		Usual Residence of Decedent											
	ylan how	.	10a. State 10b. County		10c. City,	Town or Lo	cation							10d. Inside City Limits
7	a-f s	cto	MD. Baltim	ore					S	Spar.	ks			1 ☐ Yes 2 X No
	17 th	ire	10e. Street and Number				10f. Zip	Code				10g. Ci	itizen of What Co	ountry?
	within 72 hours after death with the Maryland ene. Than "natural", or flems 23e or 28e-f show The Medical Examiner must be notitled at	Funeral Director	14221 Dove Cre	ek Way	#20	3		2	21152	2		U	nited	States
	dea	ner	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S	. 13.	Was Deced	dent of Hi	spanic Orig	gin? (Spec	cify Yes or No lican, etc.)	-	14. Race - Ame Black, Whit	
ဖွ	or the	F	1 Never Married 2 Married	1 ☐ Yes 2 💢 If Yes, Give			1 ☐ Yes		Specify:				Cassifu	
21215-0036	ours	d by	3 X Widowed 4 □ Divorced	Year or Dates:				37						White
5	72 h 'natu	Completed	15. Decedent's Edu- (Specify only highest grade	cation completed)		16a. Deced (Give	kind of wo	rk done a	lurina most	of workin	g	16b. F	Kind of Business	/Industry
21	han ne.	id m	Elementary/Secondary (0-12)	College (1-4or	5+)	life. I	DO NOT us							
N	filed with Hygiene. other that		17. Father's Name (First, Middle, Last)	0			H(	ouse	Wife		(First, Middle	Maida	Home	
ng	be fi	Be				0 3						Maluel	•	
3	2 should be 1 and Menta! I Is marked o raumatic eve	၉	William	- 0		Odger		(0)		Iele:		0'h		Bennett
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan I Health and Mental Hygiene. I Health and Mental Hygiene them 23s or 28s-f show filem 27 is marked other traumalic ovent. The Medical Examiner must be notified at other traumatic event.		19a. Informant's Name/Relationship (Ty	· ·	'C - 22									Zip Code) 21161
	1 and 2 Health tem 27 l		James B. Rutled 20a. Method of Disposition	ge III/		4000 ce of Dispo	Non (Name		\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		CL •		te Hal	
Baltimore,	Pages nent of H ant: If ite ary or of		1 Burial 2 □ Cremation 3 □ R	emoval from State		metery, crer	natory or o	ther place	1				•	
ţim	permit. Pages Department of Important: If i eny injury or once.		4 □ Donation 5 □ Other (Specify)	1	Betl	nel (	Cemet	tery	7	7/15,	/2006	Ma	donna,	Maryland
3a	permit. Departm Importa eny inju		21. Signature of Funeral Service License	* W_	111	22	. Name an			9 00	rrett	svi	lle, M	aryland
	2020d		1. Madella	n/wy									al Hom	e, P.A.
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	ne cause on each	ine.	Do not ent	_			4	respiratory a	rrest,		Approximate Interval Between Onset and Death
:5#r-	Physician		Immediate Cause (Final disease or condition	A	ORT	10	51	EN	105	15				
	/Medical Examiner		resulting in death)	Due to (or as	a conseque	ence of):								
Ġ,	- Administra		Sequentially list conditions,	Phones to toma	Carrier to the second of	es ex exp								
	ad sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	ra cunsaque	stree ory:								
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9	entific sing p	Me	IF FEMALE:	20 Hwas outcome	of program	0								
Вох	leeth certifi attending I I for use as	lan	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome 1☐Live birth	2 Fetal of	death 3	Ectopic pr					1	23d. Date of de Month	livery Day Year
	the a	sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4∏Pregnant a 9∏Unknown	it time of dea	ath 5∐	Other (sp	secity)						,
P.0	that the de led by the a detached	F.	Part II. Dther significant conditions cor	stabuting to death I	out not result	ting in the u	ndarhina c	PAUS ANG	on in Part I		23a Did t	obacco	use contribute la	the cause of death?
ŝ	ires tha signed d be det	b	Partil. Durar significant conditions con	ithouting to death t	Jul Hot 163ul	ung in une u	ilderlyllig c	ause give	miniranti.		1 🗆			robably 4 Unknown
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		Completed									1 Yes	rmed?	death? 1 ☐ Yes	2 □ No
of Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?							of Death	Check only	ne)	**	
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0	ng P		27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury ay Year)	28b. Time of Injury	2	28c. Injury Work	at	2	8d. Describe	how inju	ury occurred	
0	Attending or death.	cati	2 Accident investigation		. 100		М	1 🗆 '	Yes 2 □ !	No				
Division	I or Attendi after death. Director: A	Certification:	3 Suicide 6 Could not be determined	28e. Place of In building, e	jury - At hon tc. (Specify)		eet, factory	y, office		2	8f. Location ( City or To			ural Route Number,
D	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely tilled in by the tuneral													
	t hout tune	edical	29a. Certifier 1 Certifying Physical Check only 2 Medical Exami	sician: To the best ner: On the basis of	of my know of examination	ledge, deat	h occurred vestigation	at the lim	e, date and	d place, a	nd due to the	cause(s	s) and manner and due	s stated. e to the cause(s)
	To the Hospital within 24 hours a To the Funeral I completely tilled	Medi	one)	and manner st	tated.		200	Linna	number.			204 D	ate sissed (Moss	h Day Vand
	To To con	1	29b. Signalure and title of certifier	~~			290	C. License	number /	64	73	290. D	ate signed (Moni	.200C
•				$\mathcal{O}$			1	100		シー	, _	JV	Mis.	,
-4			30. Name and address of person who co		death (Item	23a) (Type,	Print)	Ι Λ	1/5	20	ITIM	001	= MO	,2006 21229
			SAPNA KUEH		rar's Signatu	UCF	1101	YA	VE.,	DA	V111/1		-, 100	41541,
	Sta Registi	ate rar	31. Date filed (Month, Day, Year)		ar a digital	4 1	meli	j						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** 5:20 A M June 30 2006 James Cornelius Roane /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1**X** M 2□ F Yrs. Director 1943 Wash., 579-54-8354 Usual Residence of Decedent with the Maryland 10a State 10h County 10c. City, Town or Location 10d. Inside City Limits ir than "natural", or Itame 23a or 28a-f ehow the Medical Examinar must be notified at Hillcrest Heights Yes 2 No Prince George's Director Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2543 Keating St. 20748 United States e filed within 72 hours after death Il Hygiene. other than "natural", or Itame 23. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No **Black** Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed v
Department of Health and Mental Hygies
Important: If item 27 is marked other th
eny injury or other traumatic event, the Teacher Government 6 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Joseph Carter Roane Ludie Newman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TwaWanda Norris/Niece 4303 Brookview Terr., Ft. Wash., MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State Lincoln Memorial Cem. 7/8/2006 4 □Donation 5 □Other (Specify) Suitland, MD 21. Signature of Funeral Service Licensee Stewart Funeral Home 22. Name and Address of Facility 4001 Benning Rd., NE Wash., DC 20019 23a. Part1. Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** in throw /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury (m/mown Due to (or as a conse Examiner the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions opnitributing/to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s has autopsy performed? certificate 1 ☐ Yes 2 ☐ No 1 Yes 2 → Mo or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Impatient 2 2/3/16 1 Tes 2 ER/Outpatient 3□ DOA this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 28c. Injury at Work? After 1 Matural 5 Pending investigation after death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a
To the Funerel C Fo the Hospitel 12 Confifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and medical Examiner stated. 29b. Signature and title of certified 29c. License number 29d. Date signed (Month, Day, Year) ause of death (Item 23a) (Type, Print) 30. Name and address of person 73-341 8, 1 w spaing mozog oz Aug - Su Arastoo Yazdani

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month, Day, Yea

2006

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Dustin Thomas F	1	quist State of Maryland / Department of - For State Certificate of			eg. No. 201	16 2304					
Physicia Medical Examin	n/	1. Decedent's Name (First, Middle,Last)  Dustin Thomas Rundquist		2. Date of Dear Month July 13, 20	Day Year	3. Time of Death 2154 hrs					
		4a. Facility Name (if not institution, give street and number)	b City, Town, or Location of Death		4c. County of Deat	h					
		631 Rising Sun Road  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	Rising Sun  If Under 1 Year If Under 24Hrs	8. Date of Bir	th(MM/DD/YYYY) 9. Bi	rthplace (State or					
Funeral Director		457–91–1067 1 X M 2 F 1 8 Yrs.	Months Days Hours Mir	_	Fore						
	ŀ	Usual Residence of Decedent	<u></u>	1 - 7							
ow any		10a. State 10b. County 10c. City, Town or Locati				10d. Inside City Limits  1 Yes 2XX No					
vith the Maryland s 23a or 28a-f show a e notified at once.	ţċ	MD Cecil Rising Sur	1 10f. Zip Code	1	0g. Citizen of What Cou						
he Mar t or 28	Director	631 Rising Sun Road	21911		USA						
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withir spiene her the	Completed	10 None 17. Father's Name (First, Middle, Last)	1B.Mother's Nam	e (First, Middle, I	Never Worked (First, Middle, Maiden Surname)						
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	BeC	Thomas W. Novak	Kristiv	Kristin L. Rundquist							
D 21 hould 1 nd Mer is mar	٩		Address (Street and Number or								
, MD and 2 shc ealth and tem 27 is	-	Kristin L. Rundquist/mother 631  20a Method of Disposition 20b. Place of Dispos	g Sun, MD 20c. Location - City o	r Town, State							
altimore, mit Pages lar partment of Her pportant: If ite iury or other tr		1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify  Brookview		22-2006	Rising Sur	n, Maryland					
altin mit P partme portan ury or	1	4 Donation 5 Other Specify BLOORUCEW 21 Signature of Funeral Service Licensee 22 N	lame and Address of Facility R. 7	. Foard	Funeral Ho	ome. P.A.					
	1	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	lame and Address of Facility R.7 1 S. Queen St., F	Rising S	un, MD 219						
Physician /Medical		failure. List only one cause on each line.		or respiratory ari	est, snock, or near	Approximate Interval Between Onset and Death					
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Div pital o ours aff	Certification:	4 Homicide A determined (Specify) House	r	Rising	State) 631 Rising	3 Sun Road					
Hos Fundada		29a Certifier (Check only one) Certifying Physician: To the best of my knowledge, death occu (check only one) Medical Examiner: On the basis of examination and/or investiga									
To the lawithin 2 To the complet	Medical	and manner stated.  29b. Signature and title of certifier	29c. License number		29d. Date signed (M						
		That II Y's TO HELD	O.C.M.E.		July 14, 2006						
		30. Name and address of person with completed cause of death (Item 23a)	444 Per 21 - 1 2 "	- MD 0400	4						
		Theodore M. King, Jr., MD. Assistant Medical Examiner  31. Date filed (Month, Day, Year)  32. Registrar's Signature		re, IVID 2120	1						
S Regis	tate trar	31. Date filed (Month, Day, Year) 32. Registrar's Signature 32. Registrar's Signature	<i>,</i>								

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Physic	ian	Decedent's Name (First, Middle, La.	•				2. Date of Do Month	Day		3. Time of	
/Medi	cal	ETHEL MAE R  4a. Facility Name (If not institution, give	ODRIGUEZ		4h City Town	n, or Location of De	July	5	2006 County of Death	5:00	P M
Exami	ner	RUXTON NURSIN			DENTO		am		CAROLINE		
Funeral	_	5. Social Security Number 6. S	ex / 7. Age (In yrs.	last birthday)		ar If Under 24 H		_		place (State o	r Foreign
Director		184-22-9358	□ M 20 F 104	Yrs.	MOTILITS Day	75 Flours Wil	11-03-	1901	Mar	yland	
and we		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Le	ocation					10d. Inside Cit	ty Limits
Mary -1 aho	ţō	Maryland Carolin	, T	enton						1 🗆 Yes	2 No
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23a c	ai D	425 Colonial Dr	ive		2162	.9		US	SA		
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and 2 sho ealth and n 27 is m		Penny Patrick /			.02012	Bridge l			26 S	ts 880 0	5
item 27	1	20a. Method of Disposition	20b. F	lace of Dispo	osition (Name of matory or other p		Date		ocation - City or 1		
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	je	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	uence of):							
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To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	edicai	29a. Certifier (Check only one)  Certifying Pt  Certifying Pt  Certifying Pt  Certifying Pt  Certifying Pt	nysician: To the best of my kno niner: On the basis of examina and manner stated.	tion and/or in	rvestigation, in m	y opinion, death oc	curred at the time,	date and	d place, and due	to the cause(s)	
Fo the	Me	29b. Signature and title of certification	200		29c. Lice	ense number	,	29d. Dat	te signed Month	, Day, Year)	
		) See le le	Ille MD		$\mid \mathcal{D} \mid$	35284		7	17/06	•	
		30. Name and address of person who	completed cause of death (Iter	n 23a) (Type	Print)	ense number 3528 Y Ua Shingi	fra- SL	15-	e <del>/ -</del> -	021	601
$\cup$		ANDREA &	32. Regisaar's Signa	-1	1 S. U	morlinge	0000 37	- 4	ת מטוי	711 218	707
St Regist	ate	31. Date filed (Month, Day, Year)	2008	An .	1.19						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** JUNE 30 2006 5:45PM THOMAS L. REYNOLDS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TALBOT WILLIAM HILL MANOR EASTON If Under 1 Year If Under 24 Hrs. 5. Social Security Number 6. Sex 1**X** M 2□ F 7. Age (In yrs. last birthday) 8. Date of Birth 9. Birthplace (State or Foreign **Funeral** MAR 18, 1918 Months Days Hours Min. 88 MARYLAND Director 220-05-2635 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits **ehow** item 27 is marked other than "natural", or itama 23a or 28a-f show other traumatic event, the McCical Examiner must be notified at Director 1 Yes 2 □ No MD TALBOT EASTON 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 501 DUTCHMANS LANE 21601 USA death Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed withIn 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Saltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: 2 Specify: 3 ☐ Widowed 4 ☐ Divorced WHITE Completed Decedent's Usual Occupation
 (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "ne any njury or other traumatic event, Ite Medic 2006. College (1-4or 5+) Elementary/Secondary (0-12) ENGINEER HEATING & PLUMBING 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HARRY C. REYNOLDS FAITH B. LINDSAY 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE BAYNARD/DAUGHTER 305 STARR ROAD, CENTREVILLE, MD 21617 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State CHESAPEAKE CREMATION CTR 7/3/2006 4 ☐ Donation 5 ☐ Other (Specify) STEVENSVILLE, MD 21. Signature of Soneral Service Licens FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA 200 S. HARRISON ST., EASTON, MD 21601 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician arrhythma disease or condition resulting in death) XUNINUTES /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner certificate be executed the attending physician and hed for use as the burial-transit acoute VE1134 Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy perform 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director. 25. Was case referred to medical 26. Place of Death Check onl one Be Other: 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred To the Hospital or Attending I within 24 hours efter death. To the Funeral Director; After Injury 1. Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one)

5

State Registrar

Sumoer M 31. Date filed (Month, Day, Year) JUL 0 2 2006

sumom us

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

29b. Signature and title of certifier



508

29c. License number

29d, Date signed (Month, Day, Year)

Easton MD 21601

			1 - State of Registrar	f Maryland / Depa Cer	artment of H <i>tificate of l</i>			ene2 () () 6	23052		
	Dhuaiai		Decedent's Name (First, Middle, Last)		<del>-</del>		2. Date of Death Month	Day Year	3. Time of Death		
	Physicia /Medic		Rose Elizabeth Rega	an				2006	10:30A <sup>M</sup>		
	Examin		4a. Facility Name (If not institution, give street and num	nber)	4b. City, Town, or	Location of Death		4c. County of Death			
			24712 Ridge Road  5. Social Security Number 6. Sex	7 Ame (In our Inch high doub	Dama If Under 1 Year	ISCUS If Under 24 Hrs.	8. Date of Birth	Montgon			
	Funeral Director		120-10-5410 1 M 2 F	7. Age (In yrs. last birthday) 95 Yrs.	Months Days	Hours Min.	Nov. 2,	1910 New	place (State or Foreign intry) York		
	2		Usual Residence of Decedent	10- 0:- 7-			· · · · · · · · · · · · · · · · · · ·		101 (-111 01 11 1		
	anyla ehov	_	New York New York	10c. City, Town or Lo New Yor					10d. Inside City Limits 1 Yes 2 □ No		
	28a-1	Funeral Director	New York New York		10f. Zip Code		10	g. Citizen of What Cou			
	with	흅		· + 2/		0034	109	U.S.A.	anto y :		
	ms 2%	era	11 Marital Status 12 Was Dece	ot. 34 Ident Ever in U.S. 13. 1	Was Decedent of Hi f Yes, specify Cuba		pecify Yes or No-	14. Race - Amer			
36	2 hours after death with the Maryland atural; or items 23e or 28e-f ehow ical Examiner naval be mullied at	by Fur	Armed For 1 □ Never Married 2 □ Married 1 □ Yes If Yes, Giv Year or Divorced	2 A No e	f Yes, specify Cuba I□Yes 2점 No	n, Mexican, Puerto Specify:	Rican, etc.)	Specify: Wh			
5-0036	72 hours "natural", idical Ex		15. Decedent's Education	16a. Deced	tent's Usual Occupa	ation	ring 1	6b. Kind of Business/I	ndustry		
7	filed within 72 Hygiene. hther then "nater, ine wester	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1	-4or 5+) life. I	DO NOT use retired	)	(III)	Drapery Ma	aterials		
7	filed wither the	Co	10	Re	tail Sale	-	contract of the second	and Hardwa	ire		
Maryland	\$ <u>a</u> <u>a</u> 5	Be	17. Father's Name (First, Middle, Last)				e (First, Middle, Ma				
Ĕ	should by	ဥ	Adam Yankay  19a. Informant's Name/Relationship (Type, Print)	19h Mailie	n Address (Street	Anna Anna Number or But	Youresk	City or Town, State, Zi	in Code)		
<u>8</u>	th an treum		J.S. Allen - Son-In-Law	1	•			- Sa - O' - I	10.00		
စ်	Heal Heal Hem		20a. Method of Disposition	20b. Place of Dispo	2 Ridge R sition (Name of natory or other place			laryland 2 oc. Location - City or T			
Ë	Page: ent o nt: #		1 ∑Burial 2 ☐ Cremation 3 ☐ Removal from 5 4 ☐ Donation 5 ☐ Other (Specify)	State		J	/12/06 5	alhalla, N	low Vork		
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Importent: If Item 27 is marke eny injury or other treumatic once.		21. Sign ture of Funeral Services Licensee	. 22	. Name and Address	s of Facility					
ñ	8 9 E 8		Forest L. Mille	ins 2	6401 Ridg	e Road,	s P.A., F Damascus	uneral Hom	ie 20872		
			23a. Part1. Enter the disease, or complications that controls shock, or heart failure. List only one cause on expectations.	aused the death. Do not ent					Approximate Interval Between		
	Physician		Immediate Cause (Final disease or condition	ngestive Hear	t Disease				Onset and Death Years		
	/Medical Examiner		resulting in death)	or as a consequence of):							
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ž	death certific e attending pl id for use as t	an/N	230. was decedent pregnant	come of pregnancy irth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy			23d. Date of deliv	,		
	the at	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		Other (specify)			Month	Day Year		
J.	w requires thet the de been signed by the should be detached	Ph	Part II. Other significant conditions contributing to de	eath but not resulting in the u	derlying cause give	en in Part I.	23e. Did toba	acco use contribute to	the cause of death?		
cords,	uires sign ld be	d by	Chronic Renal Insuffici		, ,		1 ☐ Yes	2 <b>∑</b> No 3 Pro	bably 4 Unknown		
င္ပ	taw req as beer 2 shou	lete	Diabetes Mellitus Type	-			24a. Was an	24b. Were aut	posy findings available		
Ä	0 5 0	Completed					autopsy performe	prior to co	opsy findings available ompletion of cause of		
<u>E</u>	sicien: Th certificate rector, pag	0	25. Was case referred to medical			26. Place of Deat	1 ☐ Yes 2 €	11 - 21	2□ No		
>	Physicien: rthis certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ II	npatient 2 ER/Outpatien	t 3 DOA Othe	er: 4 🗌 Nursing Ho	ome 5 Residen	ce 6√2Other (Speci	Daughters		
0	g eff		27. Manner of Death 1 ☑Natural 5 ☐ Pending (Mont	of Injury 28b. Time of Injury	28c. Injury Work	at c?	28d. Describe how	injury occurred	Home		
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DIVISION	al or Attendin efter death. I Director: Af d in by the fur	Certification:	determined 288. Place	of Injury - At home, farm, str ng, etc. <i>(Specify)</i>	eet, factory, office		28f. Location (Stre City or Town,	eet and Number or Rur State)	al Route Number,		
	To the Hospital or Attendi within 24 hours efter death. To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier (Check only one)  1 Certifying Physician: To the bar and mann	asis of examination and/or in	occurred at the time restigation, in my op	ne, date and place, pinion, death occur	and due to the cau red at the time, dat	use(s) and manner as e and place, and due	stated. to the cause(s)		
	To th within Fo the	Me	29b. Signature and title of certifier		29c. License	number	290	d. Date signed (Month,	Day, Year)		
	, , ,		Den Tolly	frolle.	(A) (A)	4555	5 J	uly 10, 20	06		
	<b>Б</b>		30. Name and address of person who completed caus	e of death (Item 23 (Type,	Print)	1					
	1			7703 Executiv	e Park C	ircle, Ge	rmantown	, Maryland	20874		
	Sta Registr		31. Date filed (Month, Day, Yeal 0 2006 32.	strar's Signatur	rock						

				1_ For State	State of Maryla	and / Depa			lental Hygie	ne	
				Registrar		Ce	runcate of	Death	Reg.	No.	7,23053
		Physici	ian	Decedent's Name (First, Middle, Last)						Day Year	3. Time of Death
		/Medi		Joan Ste	phenson Ru	snak	1		July	10 2006	
		Examir	ner	4a. Facility Name (If not institution, give s	4 . 1			or Location of Death	•	4c. County of Death	1.1
				The Memoria				Ston			bot
		Funeral		5. Social Security Number 6. Sex	1 7. Age (In y M 2√2 F	rs. last birthday) 68 Yrs.	If Under 1 Year Months Days		8. Date of Birth (Month, Day, Ye	ar) 9. Birth	nplace (State or Foreign untry)
	-	Director		Usual Residence of Decedent		00	l		December 22	, 1931 Pe	nnsylvania
		land w		10a. State 10b. County	10c.	City, Town or Lo	ocation				10d. Inside City Limits
		Maryland -f ehow lind at	ţ	Maryland Caroline	,	Preston					1 ☐ Yes 2 ☐ No
		with the	Director	10e. Street and Number		, , , , , , , , , , , , , , , , , , , ,	10f. Zip Code		10g.	Citizen of What Cou	untry?
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17	9	or its		1 ☐ Never Married 2 ☑ Married	1 ☐ Yes 2 2 No If Yes, Give		1 ⊡ Yes 2 ☑ No		rican, etc.)	Black, White	o, etc.
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Rusna	Maryland	2 6 5 6		19a. Informant's Name/Relationship (Typ	Husband			and Number or Rura			ip Code)
25		1 and Health em 27 sther tr		Andrew B. Rusnak  20a. Method of Disposition		-				Location - City or T	Town State
R	altimore,			1 ☐ Burial 2 ☐ Cremation 3 ☐ Re	emoval from State		osition (Name of matory or other pla	i i			
	Ë	nit. Pa artmen ortant; injury a.		4 Donation 5 Other (Specify)			Crematori		06 Do	ver, Delau	vare
	Bal	permit. Page Department o Important; If eny injury or once.	١.	21. Signature of Funeral Service License	non	1	2. Name and Addre	eral Home	. P.A.		
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	Н			snock, or neart failure. List only on	e cause on each line.		2	ng, such as cardiac c	r respiratory arrest,		Interval Between Onset and Death
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a cons	- ence	sholop.	eath			day
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			-	Sequentially list conditions, b	Due to (or as a cons	sequence of):	nen				mructos
		ted nsit	듣	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events c		roch	will b	emers	600		Lucia
		be executed sician and burial-transit	Examiner	resulting in death) Last	Due to (or as a cons			, 0	ge		19
	760,	eath certificate be ex attending physician for use as the burial	cai								
	89	flicate p phy as the			,						
	č	eath certi attending for use a	2	IF FEMALE: 23b. Was decedent pregnant 23	3c. If yes, outcome of pre-					23d. Date of deliv	very
	Ď	death a atte d for	Cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□F 4□Pregnant at time o		□Ectopic pregnanc □ Other (specify) _	у		Month	Day Year
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	ď.	w recuires that been signed to should be deta	Completed by Physician/Med	Part II. Other significant conditions con	tributing to death but not	resulting in the u	nderlying cause gr	ven in Part I.	23e. Did tobaco	co use contribute to	the causa of death?
	ĕ	ouire or sig	Pa	Chrone ob!	Lustre	ling	diser	e_	1 🗖 Yes	2 □ No 3 □ Pro	bably 4 Unknown
	ပ္ပ	s bee	plet	seral fail	ne	0			24a. Was an	24b. Were aut	opsy findings available ompletion of cause of
	æ	The lav te has age 2	E						autopsy performed	death?	
	ta	tifice for, p	a a	25. Was case referred to medical				26. Place of Death	(Check only one)	No 1 ☐ Yes	2L No
	$\geq$	ysici is cer direc	To B	examiner? 1 ☐ Yes 2 ☑ No	ospital: 1 Inpatient 2	ER/Outpatier	nt 3 DOA Ott	200		6 ☐Other (Speci	ifv)
	Division of Vital Records, P.O. Box 68	Attending Physicien: The law recuires that the death certifical rideath. sctor: Atter this certificete has been signed by the attending phy the funeral director, page 2 should be deliached for use as in		27. Manner of Death	28a. Date of Injury (Month, Day Year	28b. Time o	f 28c. Inju		28d. Describe how in		
	<u>ö</u>	ath. r: Aff	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Norm, Day You	, injury		Yes 2 □ No			
	<u>Vis</u>	r Atte	ti Ei	3 Suicide 6 Could not be determined	28e. Place of Injury - A building, etc. (Spe	t home, farm, str	reet, factory, office		28f. Location (Street City or Town, St	t and Number or Rui	ral Route Number,
	ā	s after or	Certification:		January, oto. (opt	,			o., o. ro, o.		
		To the Hospital or Attending Physicien: The I within 24 hours after death.  To the Funerel Director: After this certificate ha completely filled in by the funeral director, page		29a Certifier 1 Certifying Phys (Check only 2 Medical Examin	ician: To the best of my ler: On the basis of exam	knowledge, death	h accurred at the ti	ma, date and plane, i	and due to the dause	(s) and manner as	stated.
		the H the F the F	Medical	one)	and manner stated.						``
		To Teo	2	29b. Signature and title of certifier	Int.		29c. Licens	se number	29d.	Date signed (Month,	, uay, Year)
	7			1/12	., , , , ,		16	1042	10	My 10,	2006
				30. larm and address of person who con	mpleted cause of death (I	tem 23a) (Type,	Print)	1 1	C+ 51	51	40 2/601
				31. Date filed (Month, Day, Year)	32. Registrar's Sig	I_U . L	17 S.Wa	shriften	JI, CA	8 Jon ,	4601
		Sta Regist		7. Sate filed (Notice), Day, Tear)	Area A	Some?	2	*		,	

		For State	State of M		d / Depa		lealth and N	nental Hyg		gibici	
	v	Registrer  1. Decedent's Name (First, Middle, L	astl		Cer	lilicale of	Dealli	2. Date of Deat	eg. No:	<del>005</del>	3Time of Death
Physicia	an							Month	Day	Year	
/Medic		Mary Frances Sa  4a. Facility Name (If not institution, g		r)		4b. City. Town, o	r Location of Death	July	04 4c, Cc	2006 unty of Death	6:55 A <sup>M</sup>
Examin	ėr			.,		Salisb				comico	
Funeral		Wicomico Nursing 5. Social Security Number 6.		lge (In yrs.	last birthday)	If Under 1 Year	If Under 24 Hrs.	8. Date of Birth		O Diet	nplace (State or Foreign untry)
Director		214-10-8133	1□M 2\XF	91	Yrs.	Months Days	Hours Min.	Feb. 2,	1915	Mary	land
p.		Usual Residence of Decedent									
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<b>K</b> 2 2 2	by Funeral Director	10e. Street and Number				10f. Zip Code 21801		,		of What Co	untry?
7 ta 8 1	ra	900 Booth Street	12. Was Deceder	t Ever in II	6 121		linnania Origin? /Cr	north Voc or No.	USA	Race - Ame	écan Indian
ltam	Ë.	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces	<u>s?</u>	.5.	If Yes, specify Cuba	lispanic Origin? (Sp an, Mexican, Puerto	Rican, etc.)	14.	Black, White	
alf, or	by F	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates			1 ☐ Yes 2 🗓 No	Specify:		Sp	ecify:	White
2 hou	ted	15. Decedent's	Education		16a. Dece	dent's Usual Occup	pation		16b. Kind	of Business/l	ndustry
Pan "n	ple	(Specify only highest of Elementary/Secondary (0-12)	College (1-40	r 5+)	life.	DO NOT use retired	during most of world)	king			
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avani	Be (	17. Father's Name (First, Middle, La	_					ne (First, Middle, i		rmame)	
Via Menidia Me	၉	Alex George McCa						e Shield			<u> </u>
2 sh and is m raum		19a. Informant's Name/Relationship					and Number or Ru				
and and Health		Thomas S. Sample 20a. Method of Disposition	/Son	20h E			Leonard F	and the second s		burg, tion - City or	
in its		1 X Burial 2 Cremation 3		.8		sition (Name of matory or other place	l l				
perillincite, Ivial ylatifu 2 12 13-000 mp.  permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  The man 27 is marked other than "neturelt, or Itams 23a or 28e-f show any injury or other traumatic avant, Ital Medical Exam and must be notified at once.		* 4 □ Donation 5 □ Other (Special Signature of Funeral Service Local Se	~	Pa		Cemetery	7/8/				Maryland
Depariment of the popular of the pop		21. Signature of echeral services	1301	<i>y</i>	Zé	eller Fun	eral Home	P. 0.	Box	3171	ND 01000
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		Shock, or heart failure. List on Immediate Cause (Final	y one cause on each	line.			.,,	,			Interval Between Onset and Death
Pnysician /Medical	6 0	disease or condition resulting in death)	a ASC	<b>V D</b> as a cońseq	wanaa of).						
Examiner			Due 10 (0) 8	as a conseq	derice or,.					1	
	er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	as a conseq	uence of):						
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ing ph	Physiclan/Med	IF FEMALE:									
ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcon 1☐Live birth	2 Feta	Ideath 3	Ectopic pregnanc	у		230	<ol> <li>Date of deli</li> <li>Month</li> </ol>	very Day Year
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signed be do	d by	DIABETES									obably 4 Dunknown
w requires been sign	ete	HYPERTENSION						24a. Was a	n /	Ah Wara au	topsy findings available
e la has	Completed	HALENIE NZION	,					autops	med?	prior to death?	completion of cause of
VICAL PRICIAN: The sician: The certificate rector, pag	e Cc	25. Was case referred to medical	n <del> </del>				OC Plans of Dag	1 Yes		1 🗆 Yes	20-No
Or VITA Physician: this certific ral director,	o B	examiner?	Hospital: 1 ☐ Inpa	ntient 2	ER/Outpatie	at 3 DOA Oth	19r. Wursing H	th <i>(Check only or</i>		Other (Snec	2(5)
on or vitaling Physician:  After this certific funeral director,	n: 1	27. Manner of Death	28a. Date of Ir (Month, I		28b. Time o			28d. Describe h			,
SION tending Jeath, tor: Afte the fune	atlo	Natural 5 Pending 2 Accident investigat		Jay (Gai)	Injury		Yes 2 □ No				
VIS ratte er de recto by th	Certification:	3 Suicide 6 Could no 4 Homicide determine	280. Place of	Injury - At h	ome, farm, st	reet, factory, office		28f. Location (S. City or Town		lumber or Ru	ral Route Number,
ital o	Cer										
To the Hospital or Attending P within 24 hours after death. To the Funeral Director. After to completely filled in by the funeral	edical	(Check only 2 Medical Ex	Physician: To the be aminer: On the basis	of examina	owledge, deat ation and/or in	h occurred at the ti	me, date and place opinion, death occu	, and due to the c rred at the time, d	ause(s) ar late and pl	d manner as ace, and due	stated. to the cause(s)
the hin 2 than than mplet	Med	one)	and manner	stated.		29c. Licens	se number	2	Ord Date s	ioned (Monti	n, Day, Year)
To To cor		29b. Signature and little of certifier	Y C.				063199		710	D6	., -wj, ·vai/
			a completed	å dant- /li-	- 22a) (T				113		
		30. Name and address of person with Yogesh Vohra,					Salisbury	v. Md	21804		
Sta	te:	31. Date filed (Month, Day, Year)	# 2006 <sup>32. Reg</sup>	rar's Signa	ature	DITAE,	Darrangi	y o riu o	21004		
Registi		JUL 9	7 2006 <sup>32. Reg</sup>	Gove	J.	Apoll					

**ORIGINAL** 

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year Month **Physician** Swinton Myrtle 2006 3, 7:00 P. July /Medical 4b. City, Town, or Location of Death Upper Marlboro 4c. County of Death 4a. Facility Name (If not institution, give street and number) 14040 New Acadia Lane **Examiner** # 102 Prince George's If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Days Year) 1 ☐ M 2**X** F 90 578-34-3911 2/17/16 **Director** N. Carolina Usual Residence of Decedent 10b. County 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-1 show any injury or other traumatic event. Ith Medical Examinat must be notified at Md. P.G. Upper Marlboro 1 XYes 2 □ No Director 10e. Street and Number 10g. Citizen of What Country? 10f Zin Code 14040 New Acadia Lane # 102 20774 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Black þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) yrs. Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Horace McCall ပ Hortense Moore 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Richard Swinton/Son 13204 Vandine St., Upper Marlboro, Md. 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Lincoln Mem. Cem. 7/10/06 \* 4 ☐ Donation 5 ☐ Other (Specify) Suitland, Md. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility & Sons Co., Inc. H.S. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart lailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Arteriosclerotic Cardiovascular Disease /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner burial-transit death certificate be executed and that initiated events resulting in death) Last Due to (or as a consequence of) physician Box 68760 Physiclan/Medical the as IF FEMALE: nse 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown signed by t 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 2 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Yes 22 No this certificate has 1 Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၀ 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 28b. Time of Injury 1 Natural 5 Pending 2 No 1 TYes investigation 2 Accident Diractor: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) To tha Hospital c within 24 hours af To tha Funaral Di 29a. Certifier 1 🗆 Certifying Physicien: To the best ol my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0007967 July 5,2006 30. Name and address of person who completed cause of leath (Item 23a) (Type, Print) 20744 600 Riverbend Road, Ft. WAshington, Md. Albert E. Rolle, M.D. 31. Date liled (Month, Day, Year) 32. Registrar's Signature State JUL 0 6 2006 Registrar

			1 - For Amend Item Registrar	State of Maryl,		72117050hb		•	_	06	23057
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	th		3. Time of Death
	Physicia		Melvin Wilmer	Smith				July 2	, <sup>Day</sup>	Year	10:45 PM
<b>)</b>	/Medic Examin		4a. Facility Name (If not institution, give s	4b. City, Town, o	r Location of Deat			4c. County of Death			
			Anne Arundel Medi	cal Center		Annapo	lis		Anne	Arun	del
	Funeral Director		220-16-7416	M 2□F 7. Age (In )	vrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day 5/20/19	<sub>Уваг)</sub> 926	9. Birthp Coun Mar	lace (State or Foreign try) yland
pue	*		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	ocation				1	Od. Inside City Limits
Maryl	e. en "natural", or items 23a or 28a-f ehow Medical Exertifret blust be notified at	to	Maryland Anne Aru		Edgewa						1 ☐ Yes 2 🔀 No
with the		I Director	10e. Street and Number 1411 Park Road			10f. Zip Code 210	37	1	0g. Citizen of W		try?
deat	ms 2	Funeral	11. Marital Status	2. Was Decedent Ever i	n U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (S	pecify Yes or No-		- Americ	
OUSO hours after death with the Maryland	al', or its Exemitie	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates:	1	ir Yes, specify Cuba 1 ☐ Yes 2 🛣 No	Specify:	o Rican, etc.)	Specify.	white, white, whi	
<b>5-6</b>	"natur adical	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of wor	rking	16b. Kind of Bu	siness/Inc	lustry
21215-0030 ad within 72 hours aff	E E E	дшо	Elementary/Secondary (0-12)	College (1-4or 5+)  • Vears	me.	Engineer			Mech	nanio	al
Deliled belied	d other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's Nar	ne (First, Middle,	Maiden Sumam	9)	
arylan should be	9 3 U	To E	Morris Wilmer	Smith			Anni	e Elizab	eth Barl	æs	
Mar nd 2 sh	f Health and Mittern 27 ie mar other treumati		19a. Informant's Name/Relationship (Type Nancy B. Smith/ Da			ng Address <i>(Street</i> Worthingt					Code)
<u> </u>	<b>⊕</b> ○ <del>►</del> ►		20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Re 4 □ Donation 5 ☑ Other (Specify)□	emoval from State	•	osition (Name of matory or other place st Cemete			20c. Location -		
Dalti Permit: F	Depertment important: eny injury c		21. Signatur of Funeral Service License			2. Name and Addre					
Ď	eny eny		MULLITHELL			2973 Solo					
(60) K	Assician and Assic	Ical Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a con	sequence of):	ANCE					Onset and Death
.O. DOX 60 the death certifica	by the ettending physteched for use as th	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	□Ectopic pregnancy	,		23d. Date Mor	e of delive	ry Day Year
quires that	been signed t should be det	þ	Part II. Other significant conditions con	tributing to death but not	resulting in the u	inderlying cause giv	en in Part I.	23e. Did to			e cause of death? ably 4 □Unknown
	ate has page 2	Completed						24a. Was a autops perfori	ged? d	Vere autorior to coreath?	osy findings available npletion of cause of
OT VICE Physician:	certificat rector. pa	Be	25. Was case referred to medical examiner?	ospital: 🗸		oth Oth	or.	ath Check only on			
JO DO Sing Phys	h. After this funeral dir	lon; To	27. Manner of Death Natural 5 Pending	28a. Date of Injury (Month, Day Yea	2 ER/Outpatie 28b. Time o r) Injury	of 28c. Injur Wor	4 🗀 Nursing r	forme 5 ☐ Reside 28d. Describe he			r)
UIVISION I or Attending	ifter deat Director: in by the	Certification:	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - Abuilding, etc. (Sp.	At home, farm, st ecify)		163 2 0 10	28f. Location (S City or Town		or or Rura	l Route Number,
To the Hospital or	within 24 hours a To the Funeral I completely filled	Medical C	29a. Certifier Certifying Phys	ician: To the best of my ter: On the basis of exan and manner stated	knowledge, deat nination and/or in	th occurred at the tire	ne, date and place pinion, death occu	a, and due to the curred at the time, d	ause(s) and mai ate and place, a	nner as st	ated. the cause(s)
To th	within To th compl	Me	29b. Signature and title of dertrier	ézeml		29c. Licens	6364		9d. Pate signed	(Moeth,	Day, Year)
	16		3 ame and address of person who co	W(1) 9(1)	(Itam 23a) (Type	Print	30D -	SPANNA	US W	in	21401
	Sta Registi		31. Date filed (Month, Day, Year) JUL 2 I 2006	32. Registrar's	ignatur						

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State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1 Decedent's Name (First, Middle, Last) Month 2006 10:13 p <sup>M</sup> **Physician** June 26 Paul L. Saddler /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Prince George's Laure1 Laurel Regional Hospital 8. Date of Birth (Month, Day, Oct. 5, If Under 1 Year | If Under 24 Hrs. | 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** Months Days Hours Min. Washington, DC 1**⊠** M 2□ F 1946 579-58-9517 59 Vrs Director Usual Residence of Decedent 10d. Inside City Limits with the Maryland 10c. City, Town or Location 10a State r than "natural", or itema 23a or 28a-f ehow the Nedical Examinar must be milled at TX Yes 2 No Director Prince George's Laure1 MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 20708 8713 Contee Rd. #103 Funeral death v Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Black, White, etc. o filed within 72 hours after de I Hygiene. other than "natural", or Item 1 MaYes 2 □ No ff Yes, Give Year or Dates: 1 Never Married 2 T Married Specify: Black Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: by 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Computer Specialist permit. Pages 1 and 2 should be filed with Department of Health and Mental Hygien important; if item 27 is marked other that any injury or other traumatic security. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Alberta Chambers James Saddler 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8713 Contee Rd. #103 Laurel, MD 20708 Gwendolyn Saddler / Wife 20c. Location - City or Town, State Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Maryland Vet. Ceme. July7,2006 Cheltenham, MD 4 □ Denation 5 □ Other (Specify) 22. Name and Address of Facility Johnson and Jenkins Funeral Home 21. Sign ture of Funeral Service Licens 716 Kennedy Street NW Washington, DC 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Final disease or condition resulting in death) FATAL CARDIAC ARRHYTHMIA Physician /Medical Due to (or as a consequence of) Examiner RESPIRATORY FAILURE Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner signed by the attending physician and d be detached for use as the burial-transit The law requires that the death certificate be executed C.H.F. Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part If. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 No 3 Probebly 4X Unknown DIABETES, RECENT PNEUMONIA, COPD been signated b 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy periorm certificete has birector, page 2 s 2**X** No 1 ☐ Yes 2X No 1 Yes To the Hospital or Attending Physician: 26. Place of Death (Check only one) 25 Was case referred to medical Be examiner' Hospital: 1 ☐ Inpatient 2 🛣 ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2X No ဥ After thi 28d. Describe how injury occurred 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? Certification: 1X Natural 1 ☐ Yes 2 ☐ No investigation death. 2 Accident Director: / Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) in by 4 Homicide within 24 hours after to the Funeral Dire 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier June 28, 2006 nd address of person who completed cause of death (Item 23a) (Type, Print) Largo, MD 20774 1221 Mercantile Lane J. W. McConnell, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 [] Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** LORRINE SMITH JUNE R. 28 2006 2:30P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner PRINCE GEORGE'S HOSPITAL CHEVERLY PRINCE GEORGE'S If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, NOV • 5 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days 1 ☐ M 2 🔀 F 414-80-1304 Yrs. 59 1946 TENNESSEE Director Usual Residence of Decedent death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ges 1 and 2 should be filed within 72 hours after death with the Marylan tof Haalih and Mental Hygiene.

I of Haalih and Mental Hygiene.

If item 27 is marked other than "natural", or items 23a or 28e-f show or other fraumatic avent, the Medical Expriment made profitied at MD PRINCE GEORGE'S LANHAM 1X Yes 2 No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20706 U.S.A. 7941 JOHNSON AVENUE Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🕅 No Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 21215-0036 1 ☐ Yes 2 🗓 No ģ Specify: BLACK 3 X Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) PRIVATE DIETARY SUPERVISOR 12th Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ERENSTINE WASHINGTON UNKNOWN 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7041 TOHNSON AVENUE LANHAM, MARYLAND 20706 19a, Informant's Name/Relationship (Type, Print) 7941 JOHNSON AVENUE LANHAM, MARYLAND LISA SMITH/DAUGHTER Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a, Method of Disposition Pages 1 I Burial 2 ☐ Cremation 3 □Removal from State ō permit. Page Department of Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) ESURRECTION CEMETERY 7/10/2006 CLINTON, MARYLAND 21. Signature of Funeral S 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that award the shock, or heart failure. List only one cause on each line sed the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 menths? 2 Fetal death Month Day Year 4□Pregnant at time of death 5 Other (specify) P.O. 1 page 2 should be del 23e. Did tobacco use contribute to the cause of death? Part II, Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. à Division of Vital Records, 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 1 🗌 Yes 24a. Was an autopsy performe 1 ☐ Yes 2 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2√ No Νo Attending Physician: After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: Certification: To 1 Yes 2 No Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 27. Manner of Death Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No death. To the Hospital or Attendi within 24 hours after death To the Funeral Director; A completely filled in by the fi investigation 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signer (Month, Jay, Year) 29b. Signature and title of certifier 30318 06 and address of person who completed cause of death (I m 23a) (Type, Print) 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND M.D. James Catevenis 31. Date file (Month, Day, Year) 32. Registrar's Signature State Registrar 0 5 2006

			For State Registrar	State of Mary		artment of H rtificate of I			ene g. No. 2006	23060	
I	Physici /Medic		Decedent's Name (First, Middle, Las     Delores	t)	Smith			2. Date of Death Month JUNE	2 <sup>Day</sup> 2006	3. Time of Death	
<b>)</b>	Examin		4a. Facility Name (If not institution, give 2008 N. ANVIL LA				LE HILLS		4c. County of Deat		
	Funeral Director		1/8-32-3613	7. Age (In	yrs. last birthday, Yrs.	If Under 1 Year   Months Days	If Under 24 Hrs Hours Min.		9. Birt 8 1942 PEN	hplace (State or Foreign untry) INSYLVANIA	
Baitimore, Maryland Z1Z15-UU36  sernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.  mportent: if item 27 ie marked other then "natural; or iteme 23a or 28e-1 ehow myniqury or other traumatic event, the Madical Examinatory the publish at  DOCE.	Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  MD  PRINCE  10e. Street and Number  2008 N. ANVIL LA  11. Marital Status  1X Never Married 2 Marned 3 Widowed 4 Divorced  15. Decedent's Ed  (Specify only highest grade)  Elementary/Secondary (0-12)	GEORGE S  NE  12. Was Decedent Ever Armed Forces? 1   Yes   2 No   1 Yes   Give Year or Dates:	16a. Dece (Give life.	HILLS  10f. Zip Code 2074  Was Decedent of H If Yes, specify Cuba  1 Yes 2 No Ident's Usual Occupi Skind of work done of DO NOT use retired	ispanic Origin? (S n, Mexican, Puer Specify: ation during most of wo	Specify Yes or Noto Rican, etc.)	Black, White, etc.  Specify: BLACK  16b. Kind of Business/Industry			
	1 and 2 should be Health and Mental em 27 ie marked c ther traumatic ev	To Be Co	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)  19. REPNICE BLACKWELL.								
8/60,	Physician /Medical Examiner on the private of the p	dicai Examiner	23a. Part i. Enter the dispase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Conset (and Death Carse (Final disease or condition resulting in death)  ATHEROSCLEROTIC CARDIOVASCULAR HEART DISEASE  Due to (or as a consequence of):								
P.O. Box 6	the death certifi y the attending ached for use as	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown  Part II. Other significant conditions of	23c. If yes, outcome of pr 1 Live birth 2 L 4 Pregnant at time 9 Unknown		23d. Date of delivery Month Day Year  23e. Did tobacco use contribute to the cause of death?					
Vital Hecords,	Physicien: The law requires that this certificate hes been signed b ral director, page 2 should be deti	Be Completed	25. Was case referred to medical examiner?	Hospital:	0.00	24a. Was an autopsy perform 1 Yes 25 ath (Check only one,	autopsy performed? prior to completion of cause of death?    Yes 2♥ No 1 □ Yes 2♥ No				
Division of	ittending death. ctor: After / the fune	Certification: To	1 Nes 2 No  27. Manner of Death  1 Natural 2 Accident 3 Suicide 4 Homicide  1 No  6 Could not be determined	28a. Date of Injury (Month, Day Yea	At home, farm, si	of 28c. Injun World	/ at	oral Route Number,			
To the Hospital or A within 24 hours effer To the Funeral Dires completely filled in b)	Medical C	29a. Certifier (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier  29c. License number  29d. Date signed (Month, Day, Year)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  SALVADOR SYLVESTER M.D. 3001 HOSPITAL DRIVE CHEVERLY MARYLAND 20785  31. Date filed (Month, Day, Year)									
	Regist		JUL 0 5 2006	Block A	A Appar	E)					

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** Mary Smith 12:30pM July 3, 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner National Lutheran Home Rockville Montgomery

9. Birthplace (State or Foreign
Country) If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Mar. 26, 1912 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 2 XF Months 225-52-5349 94 Director Virginia Usual Residence of Decedent Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Intel If item 27 is marked other then "naturel", or items 23s or 28s-1 show 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or items 23a or 28a-f show treumatic event, the Mcdical Examinar must be notilised at Md. Montgomery Rockville 1X Yes 2 □ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 9701-Veirs Drive 20850 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 💆 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White þ If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Dept. Store Sales Person 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Guy Ebbert Smith Jessie Amanda Williams ပ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kristina Hughes-Executor 9701-Veirs Dr., Rockville,Md. 20850 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 1X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department of Importent: If any injury or once. ö 7/7/2006 Lovettsville, Va. Union Cemetery ¹ 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility
Hysong Co., Inc.
6510-16th St., Nw., Wash., DC 21. Signature of Funeral Service Licensee Hyson Co. Inc. 6510-16th St., Nw. Wash. I fractions that raused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, and cause on the cause of the control of 23a. Part1. Enter the disease. com Approximate shock, or heart failure. List only Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician CARDIAL DYCRRHYTHMIA /Medical Due to (or as a consequence of): Examiner HYPERTENSION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months?
1 Yes 2 No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 1 ☐ Yes 2 ☐ No 2 No or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No Certification: To filled in by the funeral 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: 6 Could not be 3 DSuicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medicai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Where Autro 2006 00051158 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20850 ROCKUILLE ANTHONY VEIRS 9701 VATTI DRIVE 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 5 2006 Registrar

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Richard Joseph Sanders 1- For State Certificate of Death Reg No Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Physician/ Month June 29, 2006 0122 hrs Medical Examine Richard Joseph Sanders 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Prince George's Prince George County Hospital Cheverly 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5 Social Security Number **Funeral** oreign Months Days Hours Director 208-32-9576 61 11/10/1944 Pennsylvania 1 X M 2 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location X Yes 2 No 28a-f show Prince George's Maryland Clinton once. Director 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? 12803 Engelhardt Ct. United States or items 23a Funeral 13 Was Decedent of Hispanic Origin? (Specify Yes or No-12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, 11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces? 1 Never Married Married 1 X Yes 4 X Divorced Widowed If Yes. Give Year 1 Yes 2 X No specify: Specify the Medical Examiner Black ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed , MD 21215-0036 and 2 should be filed within 72 ho calth and Mental Hygiene Elementary/Secondary (0-12) College (1-4 or 5+) other than 12th Transportation Private 18.Mother's Name (First, Middle, Maiden Surname) 17 Father's Name (First, Middle, Last) marked Be or other traumatic event, Jerome O. Sanders <u>Lillian Turner</u> 19a Informant's Name/Relationship (Type, Print 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) t of Health and.
'Citem 27 is me'raume' 12803 Engelhardt Ct., Clinton, MD Imposition (Name of cemetery.) Date 20c. Location - 0 Richard Sanders/Son Place of Disposition (Name of cemetery 20c. Location - City or Town, State Baltimore, I permit. Pages I and Department of Heall Important: If item 20a Method of Disposition crematory or other place) Burial 2 XCremation 3 Removal from State 7/6/2006 Clinton. Donation 5 Other Specify: Crematory 22. Name and Address of Facility 21 Signature of Funeral Service Licensee Stewart Funeral Home 4001 Benning Rd., NE Wash DC 20019 Approximate Interval I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or **Physician** allure. List only one cause on each line. Between Onset and /Medical Death a Drowning complicating Atherosclerotic Cardiovascuolar Disease Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of): Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last d. and sician/Medical physician a UNPENDED AMENDED item#28band 28e, perMD, G859,9/1/2006 TT 68760, 23d Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) Box 1 Yes 2 No 9 Unknown Unknown Phy 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I o þ 1 Yes 2 No 3 Probably 4 V Unknown Completed of Vital Records, 24b. Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? ✓ Yes 2 No 1 🗸 Yes 2 No 26. Place of Death (Check only one) 25. Was case referred to medical To the Hospital or Attending Physician: Be Other<sub>4</sub> examiner? Nursing Home 5 Residence 6 Inpatient 2 V ER/Outpatient 3 DOA 1 🗸 Yes ဂ 285 Jime of Injury 28a. Date of Injury (Month, Day Year) Jun 28, 2006 28c Injury at Work? 28d Describe how injury occurred 27. Manner of Death Certification: Subject drowned Natural Division 1 Yes 2 ✔ No 5 Pending after death 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town. State determined 9171 Central Avenue, Capitol Heights, MD (Specify) Emergency Room Bally Fitness Center 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the 1 and manner stated 29d. Date signed (Month, Day, Year) 29b Signature and title of certifier 29c. License number June 29, 2006 O.C.M.E. w 30 Name and address of person who completed cause of death (Item 23a)

Date filed (Month, Day, Year)

Ana Rubio MD.

Assistant Medical Examiner

111 Penn Street, Baltimore, MD 21201

Registrar

			1 - For State Registrar	State of Maryla		artment of rtificate of			giene 00	5 23063
	Physici /Medic		1. Decedent's Name (First, Middle, Last) Edward T. Sellm	an				2. Date of Dea	Pay 2 Yea	3. Time of Death 1700 M
)	Examin		4a. Facility Name (If not institution, give so  Anne Arundel Med  5. Social Security Number 6. Sex	dical Cent	er	4b. City, Town, Annag  If Under 1 Year			Anne Ar	undel
÷	Funeral Director	QE.	217-88-5887	M 2□F	37 Yrs.	Months Days				lirthplace (State or Foreign Country) aryland
	the Marylar 28a-f ehow culfied at	ector	Maryland Anne Art		10d. Inside City Limits					
	3a or	i Dir	1579 Star Pine	Dr.		10f. Zip Code 2140	)9		10g. Citizen of What o	Country?
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-f ehow any injury or other traumatic event, the Medical Examinar must be notified at 9068.	by Funeral Director	11. Marital Status 1  XXVever Married 2   Married 3   Widowed 4   Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates:		Was Decedent of f Yes, specify Cut		(Specify Yes or No- erto Rican, etc.)	14. Race - An Black, Wi Specify: E	
	vithin 72 ho ne. han "natur • Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usual Occu kind of work done OO NOT use retire	during most of w	vorking	16b. Kind of Busines	ss/Industry
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<u>'lan</u>	Aental Aental rked c	To Be	Robert Sellman	Jr.				ta M. Co		
Baltimore, Maryland	and 2 shores agith and N n 27 is ma		19a. Informant's Name/Relationship (Type Bertina M. Brown						r, City or Town, State ern, Md.	
	Pages 1 Iment of He tant: If Iten jury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	omoval from State	emoria	sition (Name of artists or other pla 1 Park	7-	Date 10-06	20c. Location - City of Annapoli	
Bal	permit Depar Impor any in		21. Signature of Funeral Service Licenses  Larry D. Reese	MO0483	8	21 West	St. A	nnapolis	ary, P.A , Md. 21	
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	Physician /Medical Examiner	ner	23a. Part 1. Enter the disease, or complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury)	Due to (or as a cons	equence/of):	266		ac or respiratory an	est,	Approximate Interval Between Onset and Death M I Vivia
x 68760,	leath certificate be executed attending physician and I for use as the burial-transit	/Medical Examiner	that initiated events resulting in death) Last d.	Due to (or as a consi			· · · · · · · · · · · · · · · · · · ·			
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ords, P.	8 5 8	þ	Part II, Dther significant conditions cont	ributing to death but not re	esulting in the ur	nderlying cause gr	ven in Part I.		_	to the cause of death?  Probably 4 Winknown
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Divis	To the Mospital or Attending Physician: The I within 24 hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stre	eet, factory, office		28f. Location (St City or Town	treet and Number or F n, State)	Rural Route Number,
	To the Hospital of within 24 hours at To the Funeral D completely filled in	edicai	29a. Certifier (Check only one)  1	cian: To the best of my keer: On the basis of examinand mariner stated.	nowledge, death nation and/or inv	occurred at the ti estigation, in my o	me, date and place opinion, death occ	e, and due to the courred at the time, d	ause(s) and manner a ate and place, and du	is stated. le to the cause(s)
)	To t To t	2	29b. Signature and title of pertifier			29c. Licens	5 49 5		9d. Date signed (Mon	nth, Day, Year)
				esuich	HNA	rint) An	melel	Medical	Certen	
. 6	Sta Registra	-	31. Date filed (Month Day: Year) 6 200	32 Registrar's Sign	nature	edle				

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death 2 Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month 6 1115AM **Physician** Doris Mae Sipes 29-0G /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Hospital Center Westminster Carroll If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) May 4, 1933 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Min Months Days Hours 1 ☐ M 2**X** F 73 Yrs 214-28-2279 Maryland Director Usual Residence of Decedent with the Maryland 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits r than "natural", or Items 23s or 28s-f show the Medical Examinating by conflied at 1 ☐ Yes 2X No Maryland Carroll Manchester Direct 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 3407 Augusta Road 21102 U.S.A. filed within 72 hours after death it Hygiene. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) data intake secretary hospital 12 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Depertment of Health and Mental Hy Important: If Item 27 is marked oth any injury or other traumatic event size. 17. Father's Name (First, Middle, Last) Harry M. Scheu Ethel Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Donald E. Sipes/ husband 3407 Augusta Rd. Manchester, MD 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State Pipe Creek Cemetery |7/3/2006 4 □ Donation 5 □ Other (Specify) nr. Linwood, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Hartzler Funeral Home athanine Union Bridge, MD 21791 6 E. Broadway 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) VENTRICULAR TACHYCARDIA **Physician** /Medical Due to (or as a consequence of): Examiner CARDIO MY OPATHY ISCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine DISEASE CORONARY ARTERY The law requires that the death certificate be executed attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical the 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 No 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ RENAL FAILURE ACUTE 2No 3 Probably 4 Unknown 1 🗌 Yes Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? No No 1 ☐ Yes 2 ☐ No 1 ☐ Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2√No 2 ER/Outpatient 3 DOA ို 27. Manner of Death 28b. Time of 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: Director: After Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 06-29-06 D 30263 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 200 MEMORIAL AVENUE, WESTMINSTER, MD 21157 FRANCIS KHOO, MD 32 degistrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

			For Stata Registrar	State of M	larylan				ealth a Death	and M		giene, Reg. No:-	106	23065	
	Physicia	an	Decedent's Name (First, Middle, Last)     Norma Rebecca	_	r						2. Date of Dea Month July	ath Day	2006	3. Time of Death 11:00P M	
	/Medic Examin		4a. Facility Name (If not institution, give	street and number			4b. City,		Location o	of Death	July	4c. Co			
	Funeral	56	11039 Rocky Ridge 5. Social Security Number 6. Sex	7. A	ge (In yrs. I	ast birthday)	If Unde	1 Year Days	/mar If Under: Hours	24 Hrs. Min.	8. Date of Birt (Month, Day Aug. 21		Freder	place (State or Foreign	
Max Selection	Director		216-44-0688 1 Usual Residence of Decedent	]M 2 <b>∐</b> F	88	Yrs.	MOTHERS	Days	110013	IVIII I.	Aug. 21	, 191	7 Mai	ryland	
	Aaryland f ahow	or	10a. State 10b. County  Maryland Freder	ick	10c. City	, Town or Lo		eymar					10d. Inside City Limits 1 ☐ Yes 2 🕍 No		
th the A	or 28a-	Directo	10e. Street and Number				10f. Zij	Code				10g. Citizer	of What Cou	•	
	eath w	Funeral I	11039 Rocky Ridge	Rd.	t Ever in U.	S. 13. V	Was Dece		757 spanic Orio	gin? (Spe	city Yes or No-	- 14.	U.S.A Race - Ameri		
JSO TENERS	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. If Item 27 is marked other than "natural", or items 23a or 28a-f ahow may highly or other traumatic avent, Ite Medical Evanities miss be notified at anges.	ρχ	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	Armed Forces  1 Yes 2  If Yes, Give Year or Dates:	? No		<ul> <li>13. Was Decedent of Hispanic Origin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)</li> <li>1 ☐ Yes 2 ☑ No Specify:</li> </ul>						Black, White, etc.  Specify: White		
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and	and be file fental Hy rked other tic avent,	To Be C	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Mail							Maiden Su	тате)				
Mary	and 2 should salth and Men n 27 is marke for traumatic		19a. Informant's Name/Relationship (Ty Harold G. Stover S		ng Addres					Number, City or Town, State, Zip Code) hsburg, MD 21783					
lore,	ages 1 ar nt of Hea : If Item		20a. Method of Disposition  1 Burial 2 Cremation 3 F	emoval from State		lace of Dispo emetery, crer					2006		ion - City or T		
Saitimor	permit. Pa Departme Important any injury		4 Donation 5 Other (Specify)  21. Signature of Funeral Service Licens	90	ha.	/ 22	2. Name a	nd Addres	s of Facilit	y Har	tzler F	unera	Home		
9°	40244		23a. Part1. Enter the disease, or compl shock, or heart failure. List only or	ications that cause	the death				n St g, such as		Woodsbo r respiratory ar		0 21/90	Approximate Interval Between	
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1S, P.	n requires that the de been signed by the s should be detached	bχ	Part II. Other significant conditions con	ntributing to death	but not resu	ulting in the u	nderlying	ause give	en in Part I.			obacco use	acco use contribute to the cause of death?  s 2 ⊡no 3 □ Probably 4 □ Unknown		
ecords,	a 2 C	Completed								_	24a. Was	sy	prior to co	opsy findings available ompletion of cause of	
VITAI P	page 1	a	25. Was case referred to medical						26 Place	of Death	1 Yes		death?	2 No	
0	hysici this cer al direc	To B	1 Yes 2 No	lospital:		ER/Outpatier			9r: 4 🗆 Nu	rsing Ho	me 5⊡Resid	dence 6		fy)	
	Attending Physician: In death. actor: After this certific by the funeral director,	ation:	27. Manner of Death   1 ≝Natural 5 ☐ Pending   2 ☐ Accident investigation	28a. Date of In (Month, D	lay Year)	28b. Time of Injury	м	28c. Injury Work 1 🗀 `	rat <br Yes 2 □ I		28d. Describe h	now injury o	ccurred		
DIVISION	ppital or Attending Physician: ours after death. Ieral Diractor: After this certific filled in by the funeral director,	ertification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Ir building, e	njury - At ho etc. (Specify		eet, factor	y, office			28f. Location (S City or Tox	Street and N vn, State)	lumb <b>er</b> or Rur	al Route Number,	
	Fu h	edical C	29a. Certifier 1 Certifying Phy (Check only one)	sician: To the bes ner: On the basis and manner s	of examina	wledge, death tion and/or in	h occurred vestigation	at the time, in my op	ne, date an pinion, dea	d place, th occurr	and due to the o	cause(s) an date and pla	d manner as a	stated. to the cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier	0,	/	_	29	c. License	number	(-4	9	29d. Date s	igned (Month	Day, Year)	
	MIL		30. Name and address of person who co	ompleted cause of	death (Item	1 23а) (Туре,	Print)	/>			/		1121		
	۲ Sta	to	William F. Harpe			S. Cer			Thu	rmon	t, MD 2	1788			
\$	Regist		31. Date filed (Month, Day, Year)  JUL 0 6 2	006	eve.	K	heed								

			_ For	partment of Health and Mertificate of Death	Re	g. No.2006	23066						
	Physici	an	1. Decedent's Name (First, Middle, Last) Russell Harold Scott	2. Date of Death July	7 Day 2006	3. Time of Death 1411 P M							
4	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	042)	4c. County of Death							
6.	LAdmin	CI	Laurelwood Care Center	E1kton		Cecil							
	Funeral Director		5. Social Security Number  459-56-5682  6. Sex 1 1 ★ M 2 □ F	Months Days Hours Min.	8. Date of Birth (Month, Day, JAN 30,	Year) 9. Birth Court 1938 Texa	place (State or Foreign intry) as						
	land bw		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	r Location			10d. Inside City Limits						
	Mary	tor	Texas El Paso El Pas	80			1 ( Yes 2 No						
	or 28c	Director	10e. Street and Number	10f. Zip Code	10	Og. Citizen of What Cou	•						
	ath w	rail	301 Camille Drive	79912		United Sta							
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: if Item 27 ie marked other then "natural", or Items 23a or 28e-f show springly or other treumatic event, the Medical Examiner must be matified a once.	by Funeral	1 ☐ Never Married 2 🕅 Marned 1 ☐ Yes 2 📶 No	13. Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto 1  Yes 2  No Specify:	Rican, etc.)	Black, White							
21215-0036	within 72 ho ine. .hen "natur ie Med cal	Completed	(Specify only highest grade completed) (C) Elementary/Secondary (0-12) College (1-4or 5+)	acedent's Usual Occupation give kind of work done during most of work te. DO NOT use retired)	ing	16b. Kind of Business/Ir  Railroad	ndustry						
	Hygie Hygie other t		17. Father's Name (First, Middle, Last)	18. Mother's Name	e (First, Middle, M								
Maryland	should be and Mental marked o	To Be			ou McKee								
	and 2 sh salth and n 27 le m			lailing Address (Street and Number or Run Camille Drive, El			p Code)						
Baltimore,	Pages 1 a ment of Hei ant: If Item ury or othe		1 U Burial 2 Acremation 3 U Removal from State	isposition (Name of crematory or other place)  ris & Co., Inc. 2006		Vest Ches Pennsy1va:	nia						
Balt	permit. Departitimport		21. Signature of Funeral Service Licensee  History Hicks (Risman)	Hicks Home for Fune 103 W. Stockton Str	erals, P. eet, Elk	A. ton, Maryl	and 21921						
	Obveision		23a. Part Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Approximate Interval Between Conset and Death disease or condition										
	Physician /Medical Examiner		disease or condition resulting in death)  a. Due to (or as a consequence of)	<del></del>									
	ecuted and -transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										
1760,	ate be executed sysicien and he burial-transit	Icai	d										
P.O. Box 68	the death certificate be executed y the attending physicien and ched for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delik Month	very Day Year						
	w requires that the de been signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part I.		pacco use contribute to							
I Records,	The lay	Completed			24a. Was all autops perform	y prior to co	opsy findings available ompletion of cause of						
/ita	Physician: The this certificate ral director, pages	Be	25. Was case referred to medical examiner?	26. Place of Deat	h (Check only on	Θ)							
of Vital	this aldi	To T	1 Tes 2 No 1 Inpatient 2 EH/Outp	atient 3L DOA Nursing Ho		ence 6 Other (Special own injury occurred	ify)						
on	te use	ation	27. Manner of Death  1 Natural 5 Pending 28a. Date of Iprov (Month Day Year) 28b. Tin	ne of 28c. Injury at Work?  M 1 Yes 2 No		. ,							
Division	al or Attendii after death. I Director: A d in by the fu	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of Injury - At home, farm building, etc. (Specify)	s, street, factory, office	28f. Location (St City or Town	reet and Number or Rui n, State)	ral Route Number,						
	To the Hospital or Attendir within 24 hours after death. To the Funerel Director: A completely filled in by the fu	edical C	29a. Certifier (Check only one)  Certifying Physician: fo the best of my knowledge, (Check only one)  Certifying Physician: fo the best of my knowledge, one)  To the best of my knowledge, one and making the best of my knowledge, one of the best of the	or investigation, in my opinion, death occur	red at the time, d	ate and place, and due	to the cause(s)						
	To the within To the comp	Me	29b. Signature and title of certifier	29c. License number	2	9d. Date signed (Month	, Day, Year)						
	6		30. Name and address of person who completed cause of death (Item 23a) (T)	29c. License number  DTY073  (pe, Print)  CHNUMS C.	>2 Ne	WASTER D	E 19720						
	Sta Regist	ate rar	31. Date filed (Month, Day, Year) 0 2006 32. Restrar's Signature	Sperte									

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - State Registral Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** HAZEL STEWART SANDERS 08 2006 4c. County of Death 850PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Talbot

9. Birthplace (State or Foreign Easton, Maryland
If Under 1 Year | If Under 24 Hrs. | 8. Da Genesis-The Pines 8. Date of Birth (Month, Day 1,1923) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** MARYLAND 1 M 2 X 82 Yrs. Director 212-20-3582 Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after death with the Maryland 10b. County 10c. City, Town or Location 10a. State 28a-f show n' of Health and Mental Hygiene. : If item 27 Is marked other than "natural", or Items 23a or 28a-f shov or other traumatic event, the Modical Evanther must be notified at XX Yes 2 No Director ST. MICHAELS TALBOT MD 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21663 USA 211 E. MARENGO ST. Be Completed by Funeral . Was Decedent Ever in U.S. Armed Forces? 1 Yes WNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 KNo Specify: Baltimore, Maryland 21215-0036 Specify: WHITE 3 ☐ Widowed 4 █ Divorced 16b. Kind of Business/Industry Sanders 16a, Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 1 and 2 should be filed withit Health and Mental Hygiene. NURSE MEDICAL 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) ANNIE ELLIOTT CHARLES STEWART 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) PO BOX 654, ST. MICHAELS, MD 21663 PHILLIP C. STOVALL/SON 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Department o Important: If any injury or once. 4 □ Donation 5 □ Other (Specify) CHESAPEAKE CREMATION CTR 7/10/2006 STEVENSVILLE, MD 22. Name and Address of Facility
FELLOWS, HELFENBEIN & NEWNAM FUNERAL HOME PA
200 S. HARRISON ST EASTON, MD 21601 21. Signature of Funeral Service Licensee Ostrowik' 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Malignent melanome of left mexillery sinus Immediate Cause (Final disease or condition resulting in death) 42273 Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, attending physician Physician/Medical the use 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Day Month for in the past 12 months? 1 ☐ Yes 2 No 5 ☐ Other (specify) Division of Vital Records, P.O. detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 2 estebral metastases 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 DUnknown 40m above-Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an perform 1 ☐ Yes 2 ☐ No 1 Yes To the Hospital or Attending Physician: 26. Place of Death Check on one 25. Was case referred to medical examiner? Be Other: Hospital: Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 💸 No 1 Inpatient 2 ER/Outpatient 3 DOA P this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred filled in by the funeral 27. Manner of Death Certification: after death. Director: After Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 24 hours a Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) within 2 To the 29d. Date signed (Month, Day, Year) 29c. License number

State Registrar 29b. Signature and title of certifier

31. Date filed (Month, Day, Yea

30. Name and address of person who completed cause of

32. Regi

(Item 23a) (Type, Print)

7.10.06

MD 21601, Michael

			. For	State	of Marylar						ental Hyg	jiene,		00000	
			- State Registrar			Cei	rtificate	e of L	Death		R	eg. No.	006	23068	
ı	Physicia	217	Decedent's Name (First, Middle, L.	ast)							<ol><li>Date of Dea Month</li></ol>	th Day	Yeer	3. Time of Death	
	/Medic		Josephine	V. St	trausser	· 					Ju1y	7,	2006	12:00 A M	
	Examin	er	4a. Facility Name (If not institution, gr	ve street and n	um <i>ber)</i>				Location o	Death		4c. 0	County of Dea	ath	
			11812 Collins I		7.4	t 1 t l-1 t - 1 . 1	Ger If Under	mant		24 Hrs	0.0		Montgo		
	Funeral		5. Social Security Number 6. 579–30–3173	Sex 1 □ M 2 双 F	7. Age (In yrs. 77	Yrs.	Months	Days	If Under:	Min.	8. Date of Birth (Month, Day Aug. 19	Year)	28 Ma	rthplace (State or Foreign Country)	
	Director		Usual Residence of Decedent		11						Aug. 19	, 10	20 110	aryland	
	/land		10a. State 10b. County		10c. Ci	ty, Town or Lo	cation							10d. Inside City Limits	
	Mar	ţ	Maryland Montgon	nery	Ge	rmanto	wn					1 ☐ Yes 2 🙀 N			
	h the	Directo	10e. Street and Number				10f. Zip	Code				0g. Citiz	en of What C	Country?	
	death with the Maryland me 23a or 28e-f ehow finust be tradified at		11812 Collins	Drive				2087	6	Ī				.A.	
	- dea	Funeral	11. Marital Status	Armed F	cedent Ever in U orces?	l.S. 13.	Was Deced	lent of Hi	spanic Orig	gin? (Spe , Puerto	cify Yes or No- Rican, etc.)	1	4. Race - Am Black, Wh	erican Indian, ite, etc.	
9	or it		1 Never Married 2 Married	If Yes, G			1 □ Yes 2		Specify:			-	Specify:		
ğ	within 72 hours after ene. than "naturel", or ite ta Medicel Exernin	d by	3 Novidowed 4 □ Divorced	Year or	Dates:	160 Dass	dente Haus	10	****			16h Kin	d of Busines:	White	
5	"nat	Completed	15. Decedent's 1 (Specify only highest g	rade completed	1)	16a. Dece	kind of wor DO NOT us	n Occupa rk done d se retired	ition <i>uring</i> mosi )	of worki	ng	lob. Kin	a of Busines:	s/industry	
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2	should be filed within 72 hours after death with the Marylar of Mental Hygiene. marked other than "naturel", or theme 23a or 28e-1 ehow imatic event, the Medical Examinating that it is mailed.		17. Father's Name (First, Middle, Las	st)					18. Mothe	r's Name	(First, Middle,	Maiden S			
an	id be ental ked o	To Be	Brown Corneliu	s Turn	er					Bert	ie Re	vno1	is		
Maryland 21215-0036	should ind Men inarke umatic	-	19a. Informant's Name/Relationship			19b. Maili	ng Address	(Street a			il Route Numbe			Zip Code)	
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altimore,	of He of He fitem r oth		20a. Method of Disposition			Place of Dispo	sition (Nan	ne of			ate			r Town, State	
Ĕ	Pag ent nt: t		1 ☐ Burial 2 TX Cremation 3 4 ☐ Dopation 5 ☐ Other (Spec		n State Me	tropol:	itan (	Crema	atori	um	7/9/06	Ale:	xandri	a, Virginia	
a	permit. Departm Importe any inju		21. Signature of Funeral Service L/c	ensee >		) No	Name an	d Addres	s of Facilit	y i ame	P.A.,	Funa	ral Ho	mα	
<u>m</u>	89 E € 9		Wrest d	- Nu	llan	26	5401 F	Ridge	Roa	d.	Damascu	S. M	arvlan	d 20872	
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that y one cause on	hat caused the death. Do not enter the mode of dying, such as cardiac or respirato on each line.							est,	-	Approximate Interval Between	
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ı	/Medical Examiner		resulting in death)		o (or as a consec										
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_	pe #	lne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury COPD												
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	leath certificat attending phy I for use as the	Z	IF FEMALE: 23b. Was decedent pregnant		utcome of pregn		7 <b>C</b> i					23	3d. Date of delivery		
P.O. Box	The law requires that the death certifica ste has been signed by the attending ph bage 2 should be detached for use as th	Physician/Med	in the past 12 months?	4□Pre	birth 2 ☐ Feta gnant at time of o		Ectopic pro Other (sp.						Month	Day Year	
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	as tha	by P	Part II. Other significant conditions	contributing to	death but not res	sulting in the u	nderlying ca	ause give	n in Part I.					to the cause of death?	
ğ	equir en si ould l									_	1 🗆 Y	es 2	INo 3□F	Probably 4 ⊠Unknown	
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ij	icien: Th certificete rector, pag	Be	25. Was case referred to medical examiner?	No. or its to				100		of Death	(Check only or	16)			
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<u> S</u>	or Attending efter death. Director: After in by the fune	cat	2 Accident investigate 3 Suicide 6 Could not	be 200 Blad	ce of Injury - At h	ome farm str			162 2 1		28f Location (S	treet and	Number or 6	Rural Route Number,	
Division of		Certification:	4 ☐ Homicide determine		ding, etc. (Speci		oot, lactory	, onice			City or Tow			istat riosio regilisor,	
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١			J-88- J	edela	in	NO		D006	50044			Ju	ly 9,	2006	
	I()		30. Name and address of person wh	o completed ca	use of death (Ite	m 23a) (Type,	Print)								
	10		Jesse Sadikman				Farm	Road	1, G	erma	ntown,	Mary.	land	20876	
	Sta		31. Date filed (Month, Day, Year)  JUL 1 0		Rigistrar's Sign		hook								
	Registr	ar	JULIU	2000	HERENAL .	N 19									

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician  $Ju\mathbf{1}\mathbf{y}^{\mathbf{0}}\mathbf{0}$ , Marian L. Stine 2006 6:25 A.M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Northhampton Manor Frederick Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days 1 □ M 2 1 F 217-28-5988 Yrs 76 October 14, 1929 Director Maryland Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits **ehow** treumatic event. Its Mudical Examiner must be notified at 1 RyYes 2 No Directo Maryland Frederick Frederick 28a-f 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 9 238 United States 200 E. 16th Street 21701 death v Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) or Iteme 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "naturel, or Item any injury or other treumatic event, the Mudical Exercement 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify Specify 3 ☑ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Edgar Welty Laura Baker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Inwood, West Virginia 25428 Linda Davis / Daughter 11 Mingo Court 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition July 10, 2006 1 

Burial 2 □ Cremation 3 □ Removal from State 4 Donation 5 Other (Specify) St. Paul's Lutheran Jefferson, Maryland 22. Name and Address of Facility Stauffer Funeral Homes, P.A 21. Signature of Fur 1621 Opossumtown Pike Frederick, Maryland 21702 23a. Part1. Enter the disease of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PANCYTOPENIA YEARS /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit law requires that the death certificate be exec Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4☐Pregnant at time of death 5 ☐ Other (specify) the 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ sate has been signi page 2 should be 1 Yes 2 No 3 Probably 4 Unknown CIRRHOSIS Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an DIABETES certificate has 2 2 No 1 ☐ Yes or Attending Physician: After this certific funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury 1 Natural 5 Pending 1 Yes 2 No within 24 hours after death. To the Funerel Director: A investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cal 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 6/06 G D32171 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) POBOX 328 WALKORSVILLE, MD RICHARD L. GOUGH Registrar's Signature 31. Date filed (Month "JUL 1"0 2006 State Registrar

			1 - For State Registrar	State of Marylar		epartment of Certificate of			Reg. No	200	23070
	Physici		Decedent's Name (First, Middle, III)     Scott W		e			2. Date of De Month	Da Da		3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, g Peninsula Regin	nive street and number)		4b. City, Town,	or Location of Death	1		County of Death	1
	Funeral Director			. Sex 7. Age (In yrs. 1	last birt		r If Under 24 Hrs.		rth a <i>y, Year</i> 952	9. Birti	nplace (State or Foreign untry) York
	ow et		Usual Residence of Decedent  10a. State 10b. County	10c. Ci	ity, Town	or Location					10d. Inside City Limits
	e Man	ctor	Maryland Wico	mico S	alis	sbury					Y Yes 2 No
	death with the Maryland rms 23a or 28a-1 ehow r.natal.ke notified at	ai Directo	906 Beaglin Pa	rk Drive		10f. Zip Code 218			-	itizen of What Co ISA	untry?
	n 72 hours after death with the Marylan "naturel", or flems 23s or 28s-1 show polical Exertificat nast ke notified at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 1∑Yes 2 □ No If Yes, Give Year or Dates: Nav		13. Was Decedent of If Yes, specify Cu		pecify Yes or No o Rican, etc.)	0-	14. Race - Ame Black, White Specify:	
Baltimore, Maryland 21215-0036	within 72 hc ene. than "natur he Medical	Completed	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	Education grade completed) College (1-4or 5+)	16a.	Decedent's Usual Occi (Give kind of work don life. DO NOT use retir Teacher	upation e during most of wor ed)	king		Kind of Business/	
land 2	ild be filed lental Hygir ked other ic event, li	To Be Co	17. Father's Name (First, Middle, Last)  Stanley Wade Satterlee  18. Mother's Name (First, Middle, Maiden Sumame)  Doris Louise Wilcox								
, Mary	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: if item 27 is marked other than any injury or other traumatic event, III a Mance.		19a. Informant's Name/Relationship Karen Satterlee	/wife	3	Mailing Address (Stree 322 Mill Po	nd Lane #	716, Sa	lisb	ury, MD	21804
limore	Pages 1: Iment of He tant: If iten jury or oth		20a. Method of Disposition 1 ☐ Burial 2 XCremation 3 4 ☐ Donation 5 ☐ Other (Spe	city) Sa		Disposition (Name of y, crematory or other pi oury Cremat	ory 7/5	-	Sa	ocation - City or lisbury,	MD
Ball	Departimonal Important Imp		21. Signature of Funeral Service Lie	bornes (FC)	0	<sup>2</sup> HÖTTÖWÂY 501 Snow	"fuheral Hill Rd.	Home Pro , Salish	ofes bury	sional A , MD 218	ssociation 04
	Physician		23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition	omplications that caused the deality one cause on each line.	ath. Don	not enter the mode of dy	ying, such as cardiac	or respiratory a	arrest,		Approximate Interval Between Onset and Death
8885	/Medical Examiner	16	resulting in death)  Sequentially list conditions,	b. Caralia Due to (or as a conse	ie	conest	3				
118-43-	ficate be executed physicien and s the burial-transit	edicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	ry	arten dis	ease				
oft,	ath certi ittending or use a	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Fet 4 Pregnant at time of 9 Unknown	al death	3 ☐ Ectopic pregnan 5 ☐ Other (specify)	23d. Date of delivery Month Day Year				
د, Sc rds, P.(	iaw requires thet the de es been signed by the a 2 should be deteched f	5	Part II. Other significant condition	s contributing to death but not re-	sulting in	the underlying cause o	given in Part I.		tobacco Yes 2		the cause of death?
$Sa$ $f$ $er$ $l$ $e^{s}$ , of Vital Records,	The ate h page	Completed						24a. Was auto perf 1 Yes	psy ormed?	death?	topsy findings available completion of cause of 2□ No
Saz	Physician: r this certific ral director,	To Be	25. Was case referred to medical examiner?  1  Yes 2 No	Hospital: 1 Inpatient 2	∃ER/Out	tpatient 3□ DOA	26. Place of Dea			6 □Other (Spec	ufv)
	g af		27. Manner of Death  1/ Natural 5 Pending  2 Accident investiga	28a. Date of Injury (Month, Day Year)	28b. T	Fime of 28c. In		28d. Describe			
Division	To the Hospital or Attendi within 24 hours efter deeth. To the Funerel Director: A completely filled in by the fu	edical Certification:	2 Accident investiga 3 Suicide 6 Could no 4 Homicide determin	t be Read of laive. At h	home, fai			28f. Location City or To	(Street a	and Number or Ru te)	ral Route Number,
	ne Hospitte 124 hours ne Funere letely fille	dicai	29a. Certifier (Check only one)  Certifying  Certifying	Physician: To the best of my kn kaminer: On the basis of examin and manner stated.	nowledge nation and	e, death occurred at the d/or investigation, in my	time, date and place opinion, death occu	, and due to the trred at the time	cause(:	s) and manner as nd place, and due	stated. to the cause(s)
	To th withir C To th comp	×	29b. Signature and title of certifier	lonam Mois	ho		nse number			ate signed (Monti	
	200		30. Name and address of person w	ho compresed cause of death (Ite gan 540 Rive 32. Registrar's Sign 2006	em 23a) (	(Type, Print)			Ju	ne 30, 2	2006
	St	ate	Dr. James Move 31. Date filed (Month, Day, Year)	gan 566 Rine 32. Progistrar's Sign	Y Sz	de Drive,	SwiteB	204, Sa	V; 56	ory Md =	31801
	Regist		JUL 0 7	2006 Burn.	H.	Sparker					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day 4:45A M **Physician** July 2006 Daniel A. Terzi /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Howard Ellicott City 2414 Mt. Hebron Drive Birthplace (State or Foreign Country) If Under 1 Year If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year, 5. Social Security Number **Funeral** Months Days Hours 1 AM 2 F Yrs 29, 77 1928 Maryland 214 22 2038 Director Usual Residence of Decedent 10d Inside City Limits with the Maryland 10c. City, Town or Location 10b. County 10a State ir than "natural", or Itamis 23a or 28a-f show the Medical Examiner must be notified at 1 TYes 2X No Directo MD Ellicott City Howard 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 21042 2414 Mt. Hebron Drive death v Funeral 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No
If Yes, Give
Year or Dates: 1951-55 1 Never Married 2 Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: þ 3 ₩idowed 4 Divorced White s 1 and 2 should be filed within 72 ho if Health and Mental Hygiene. Item 27 is marked other than "natur. other traumatic event, the Medical Is Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16h. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Adeline Minuso Narciso Terzi 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) item 27 i 2764 Thornbrook Rd Ellicott City, MD 21042 Lynn Wilson/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition Pages nent of h permit. Pages Department of Important: If it any injury or o 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State \* 4 □Donation 5 □ Other (Specify) Crest Lawn Mem. Gard. 7-10-2006 Marriottsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Harry H. Witzke's Family FH Inc. M01044 Sten 4112 Old Columbia Pike Ellicott City, MD 21043 20 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Devi Immediate Cause (Final disease or condition resulting in death) 7A5 month **Physician** /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed burial-tran Due to (or as a consequence of): attending physician Division of Vital Records, P.O. Box 68760, Physician/Medical the use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) the 9 Unknown 9 Unknown signed by 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ pe 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 No Completed been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 2 **3**No 1 Tyes certificate 1 Yes 2 No or Attending Physician: 26. Place of Death (Check only one) funeral director, 25. Was case referred to medical Be examiner' Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No Certification: To this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident after death illed in by the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 T Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital within 24 hours a 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c License number 29b. Signature and the 30129 July 6, 2006 30. Name a d address of person who/completed cause of death (Item 23a) (Type, Print) Charles St BALTIMY MM 21204 32. A gistrar's Signature 31. Date filed (Month. State 2006 JUL Dark Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No.-2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Lula F. Upchurch Ju1y 2006 0201 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign
Country) **Funeral** 1 M 2 F Maryland 100 Yrs. 214-18-0423 1906 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State or 28e-f show Item 27 is marked other then "natural", or Items 23a or 28e-1 show other treumatic event, the Modical Examinar must be notified at ₩Wes 2 No Maryland Anne Arundel Annapolis Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number With 21403 USA 1110 Madison St. Apt Al Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 2 should be filed within 72 hours after c , and Mental Hygiene. is marked other then "natural", or Iten ☐Yes 2M No Yes. Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes XXVo Specify 3 Widowed 4 X Divorced Year or Dates 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Self Employed 12th O Beautician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 1 and 2 should be Health and Mental James Makell Mary Davis ပ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Pages 1 and 2 nent of Health a ent: ff Item 27 is 1240 D Gemini Dr. Annapolis, Md. 21403 Arlene Thomas(Niece) 20b. Place of Disposition (Name of certified colors) crantator(Colors) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State permit. Page Department c Importent: ff injury or 7-6-06 Memorial Gardens Annapolis, Md. ' 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Wm. Reese & Sons Mortuary, P.A. hu West St. Annapolis, Md. 21401 821 Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** 5 year Demento disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner the death certificate be executed burial-tran and that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, nding physician Physician/Medical the use as IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b Was decedent pregnan atter 2 Fetal death 3 Ectopic pregnancy Day jo Month Year in the past 12 mont 4 Pregnant at time of death 5 Other (specify) , per 1 Yes 2 No the 9 Unknown signed by the 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 Pes 2 ■ No 3 Probably 4 Unknown Ostro porosis Completed been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? page 2 certificate 1 Yes 2 No 1 Yes 2 No director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) P 1 🖸 Yes 2 3 N 1 Impatient 2 ER/Outpatient 3□ DOA this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 28c. Injury at Work? Certification: After or Attending 1 Natural 5 Pending investigation after death.

Director: Af
d in by the fur 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined filled in by 4 Homicide within 24 hours a To the Funerel [ Hospitel 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) and manner stated. 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certified 2006 30. Name and address of person who completed cause of death-(tem 23a) (Type, Print) 2114 SEVERIVA PARK STEVAENV VATZ Cr 10 3١ RODINSON EDAD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State THE O P KNAN Registrar

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- 21	· ·	34	Decedent's Name (First, Middle, La	ast)					2. Date of Dea	ath	V	3. Time	of Death
ef.	Physicia /Medic		Anna M. Vargo						July	Day 4, 2	2006	1:20	A M
	Examin		4a. Facility Name (If not institution, gi	ve street and nun	nber)		4b. City, Town, or	Location of Dea	th	4c. County	y of Death		
		· .	College View Nu	rsing Ho	ome	_	Frederi			Fre	ederi	.ck	
	Funeral Director	1		Sex 1□M 2√F	7. Age (In yrs. i	ast birthday) Yrs.	If Under 1 Year Months Days	Hours Min		y, Year) 3,1940	Cou	place (State intry) nsylv	ania
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	ne 23	Funeral	11. Marital Status	12. Was Dece	edent Ever in U.	S. 13. V	Vas Decedent of Hi Yes, specify Cuba		Specify Yes or No-		ce - Ameri	ican Indian,	
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Maryland 21215-0036			19a. Informant's Name/Relationship				g Address (Street a					o Code)	
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9 X	eath certific attending p	Physician/Me	IF FEMALE:	23c. If yes, out	come of pregna	incy				23d Da	ate of deliv	erv.	
Box	atter d for L	clar	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No		inth 2 □ Fetal ant at time of de		Ectopic pregnancy Other (specify)				onth	Day	Year
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ري. م	res that igned to be det	by P	Part II. Other significant conditions	contributing to de	eath but not resi	ulting in the u	nderlying cause give	en in Part I.	23e. Did to	obacco use con	itribute to t	the cause o	f death?
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ita	striffica ctor,	Be	25. Was case referred to medical examiner?					26. Place of De	eath Check only o				
× >	hysic his ce Il dire	P	1 ☐ Yes 2 No	1		ER/Outpatien		4 Nursing	Home 5 ☐ Resid			fy)	
Ē	ing P	<u></u>	27. Manner of Death  1 ☑ Natural 5 ☐ Pending		of Injury th, Day Year)	28b. Time of Injury	Work		28d. Describe I	now injury occu	rred		
Sic	death. death. ctor: A y the fu	cat	2 ☐ Accident investigate 3 ☐ Suicide 6 ☐ Could not	he	-4.10			Yes 2 □ No	296 Legation /	Stroot and Miss	bosos Du	of Courts M	· · · · · · · · · · · · · · · · · · ·
Division of Vital Records,	lor Al efter d Direction by	Certification:	4 ☐ Homicide determine	288. Place	ng, etc. (Specify	ome, tarm, str y)	eet, factory, office		28f. Location (S City or Tox		ber or Hur	ai Houte ivi	imber,
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours effer death.  To the Funeral Director: After this certificate has been signed by the attending physicien and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit		29a. Certifier 1 Certifying F	Physician: To the	best of my kno	wledge, death	occurred at the tin	ne, date and place	e, and due to the	cause(s) and m	nanner as s	stated.	
	HO: 124 h	edicai	(Check only 2 Medical Expone)	aminer: On the b	asis of examina ner stated.	tion and/or in	vestigation, in my o	pinion, death occ	curred at the time,	date and place,	, and due t	the cause	∍(s)
	To th withir To th comp	Me	29b. Signature and title of certifier			Δ.	29c. Licens	e number		29d. Date signe	ed (Month,	Day, Year	)
			200	Sho	ah H	roon	mp	D516	343	76	06		
	01		30. Name and address of person wh	completed caus	se of death (Item	1 23а) (Туре,	Print)		mich 1				
	1		65 CT1	omas	3 Tho	non	- Y~	trese	more 1	NO de	702		
	Sta		31. Date filed (Month, Day, Year)	2006 32. 8	gistrar's Signa								
	Regist	ar	302 - 0	2000	The .	B 1	sail !						

DHMH 17 Rev 1/2001

ORIGINAL

		1	State of Maryland / D	epartment of Hea	ilth and Me		ene 1. No.2 0 0 6	23074
	20 4		1. Decedent's Name (First, Middle, Last)	00/10010 0. 20		. Date of Death		3. Time of Death
- Ag	Physicia	an	Edward Lee Walton		J	Month 1,	2006	3:15 a <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Loc	cation of Death		4c. County of Deat	
		4	Prince Georges Community Hospital	Cheverly	Hodor 24 Hrs. T.	D : 10:45	Prince G	
	, Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birt		Under 24 Hrs. 8 lours Min.	Date of Birth (Month, Day, )  Jan. 27,	(ear) 9. Bini	nplace (State or Foreign untry) arwater, S.C
la.	Director	-	579-50-2 <del>655=</del>			Jan. 2/9	1939 010	arwater, b.o
	yland		10a. State 10b. County 10c. City, Town	or Location				10d. Inside City Limits
	Ba-f	cto	Maryland Prince Georges Capi	tol Heights				M2XYes 2 □ No
	ith th	Die.	10e. Street and Number	10f. Zip Code		109	g. Citizen of What Co United St	
	s 23s	ara i	904 Logwood Rd.  12. Was Decedent Ever in U.S.	20743	nic Origin? (Speci	fv Yes or No-	14. Race - Ame	
36	s 1 and 2 should be filed within 72 hours after death with the Maryland I Health and Mental Hyglene. Item 27 is marked other than "naturel", or items 23s or 28s-f show other traumatic event, the Marical Exameter must be notified at	by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  15 Yes 2 No 6/30/50 If Yes, Give Year or Dates: 3/31/69	13. Was Decedent of Hispan If Yes, specify Cuban, N 1 ☐ Yes 2 No S	nexican, Puerto Ri Specify:	can, etc.)	Black, White	
21215-0036	2 hou	ted		Decedent's Usual Occupation (Give kind of work done during	n na most of working	, 10	6b. Kind of Business/	Industry
218	within 7 ene. than "n	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	.g ,,,,,,,,			
21	e filed within al Hygiene. cother than "	S	•	ccountant	. Mother's Name (	First Middle M	Governmen	T.
and	ntal H od otl	Be	17. Father's Name (First, Middle, Last)  Jake Brown		Lucille I		aldon bamamo,	
Maryland	2 should be and Mental is marked (	2		. Mailing Address (Street and			City or Town, State, 2	(ip Code)
Ma	nd 2 still ar ar ar trau		Margaret B. Walton /Wife 90	4 Logwood Rd.	Capitol	Heights	s, Md. 20	743
ē,	s 1 and 2 of Health a item 27 la		20a. Method of Disposition 20b. Place of cameter	Disposition (Name of ry, crematory or other place)	Da		0c. Location - City or	Town, State
E	Pages nent of I nnt: if its ury or o		120 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)  Arling	ton National (	Cem. 7/2	7/06 <i>A</i>	Arlington,	Virginia
Baltimore,	permit. Page Department of important: if any injury or once.		21. Signature of Funeral Service Licensee	22. Name and Address of Alexander, 5538 Marib		Funeral / Fores	Homes, Pa	A. 20747
护			23a. Part I. Enter the disease, of complications that caused the death. Do shock, or heart failure. List only one cause on each line.	not enter the mode of dying, s	such as cardiac or	respiratory arres	st,	Approximate Interval Between Onset and Death
4	Physician		Immediate Cause (Final disease or condition	Imonery A	west			Ongot and Boatt
	/Medical Examiner		resulting in death)  Due to (or as a consequence	of):	disca.	Ca		
		<u></u>	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence					
	nsit	nin.	cause. Enter Underlying Cause (Disease or injury	Molletin	Uyher	lensi	on	
Ċ,	execting and rial-tra	Examine	that initiated events resulting in death) Last Due to (or as a consequence	2 0	1 0		model	(
8760	tate be executed by sician and the burial-transit	cai	6. End Slage	Renal	failer	e Me	modely	Sy
9	ntifica ing ph e as th	Med	IF FEMALE:					
Вох	The law requires that the death certificate be executed the has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Medicai	23b. Was decedent pregnant in the past 12 months?  4 Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of de Month	ivery Day Year
	he de / the a	ysic	1 Yes 2 No 9 Unknown 9 Unknown	3 Utilet (specify)				
, P.O	that the dended by the a		Part II. Other significant conditions contributing to death but not resulting	n the underlying cause given i	in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ecords,	quires in sign	ed by	G. I Steeding.			1 ☐ Yes	s 2⊠No 3∏P	obably 4 Unknown
000	aw requir is been si 2 should	plet	Penpheral Vaccilar dise	ere		24a. Was an	24b. Were a	utopsy findings available completion of cause of
$\alpha$		Completed	injected leg uleers			perform	ed? death?	2□ No
ita	iicien: Th certificate rector, pag	Be (	25. Was case referred to medical examiner?		6. Place of Death	(Check only one	)	
of Vital	ding Physicien: n. After this certific funeral director,	2	1				nce 6 Other (Spe w injury occurred	cify)
	ding F h. After funera	lon	1) Salvatural 5 □ Pending (Month, Day Year)	Injury Work?	s 2 □No	od. Describe flor	w mjary occurred	
Division	Attending Physicien: r death. ector: After this certifici by the funeral director, i	fica	3 Suicide 6 Could not be 28e. Place of Injury - At home, for	arm, street, factory, office	2		eet and Number or R	ural Route Number,
Ö	after after Dire	Certification:	4 Homicide determined building, etc. (Specify)			City or Town,	, 5(2(9)	
	To the Hospital or Attendi within 24 hours after death. To the Euneral Director: A completely filled in by the fu	edical (	29a. Certifier (Check only one)    Certifying Physician: To the best of my knowledge   Check only one   Certifying Physician: To the best of my knowledge   Certifying Physici	e, death occurred at the time, nd/or investigation, in my opini	date and place, a ion, death occurre	nd due to the ca d at the time, da	use(s) and manner a ite and place, and du	s stated. e to the cause(s)
	To th within To th comp	Me	and at a few few days of contisting	29c. License n	umber	29	d. Date signed (Mon.	h, Day, Year)
			I hauful Singel	0001	1787	J	nly 1 2	006
R	(8)		30. Name and address of person who completed cause of death (Item 23a)  RISHPAL SINGH 7525 GREE	(Type, Print)  ZNINAY. CEN	TER D	RIVE C	Treen Bels	1 Mg
	St Regist	ate rar	31. Date filed (Month, Day, Year)  JUL 0 5 2006  32. Registrar's Signature	and .			2	0770

DHMH 17 Rev 1/2001

			1 = For State Ragistrar	State of Marylan		rtment of H			iene 2 0	06	23075
	*		1. Decedent's Name (First, Middle, Last	)				2. Date of Dea Month	th Day	Year	3. Time of Death
	Physicia /Medic		Harry F. Wi	right, Jr.				June 3	2006		5:42 A M
	Examin		4a. Facility Name (If not institution, give			4b. City, Town, or		th	4c. County		
		щ	1314 St. Josephs 5. Social Security Number 6. Se		(m m t th inth ato )	Crown:	sville	S P Date of Birth	Anne		
	Funeral Director		X X	x 7. Age (In yrs. : 74	Yrs.	Months Days	Hours Mir		931		place (State or Foreign
		ŀ	155-24-8378 Usuel Residence of Decedent								Jersey
	how		10a. State 10b. County	10c. Cit	y, Town or Lo	cation				1	0d. Inside City Limits
	e Ma	cto	Maryland Anne Ar	undel	Cro	wnsville					1 Yes 2 No
	3a or 2	al Director	1314 St. Josephs	Ct.		10f. Zip Code 21032	2	1	0g. Citizen of V USA	/hat Cour	ntry?
	deat	Funeral	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?		Vas Decedent of Hi Yes, specify Cuba	spanic Origin? (	Specify Yes or No-		- Americ	an Indian,
39	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "naturel", or Itema 23a or 28e-f ehow eumatic event, it e Madical Exacilination in the Madical Exacilination.	by	1 Never Married 2 Married 3 Widowed 4 Divorced	1 Yes 2 No If Yes, Give Year or Dates:		☐ Yes 2 No	Specify:	10 1 1041, 0.0.,		Whi	
Ď	72 ho	Completed	15. Decedent's Edu (Specify only highest grad			lent's Usual Occupa		orkina	16b. Kind of Bu	siness/In	dustry
2	ithin 19.	nple	Elementary/Secondary (0-12)	College (1-4or 5+)	life. L	OO NOT use retired	)	9		_	
2	led w lygier her th		17. Father's Name (First, Middle, Last)	5+ years	Ba	nker	10. Mathada Na	me (First, Middle,		nking	1
and E	ould be filed wi Mental Hygien arked other th	Be		at abla Can				lan Strum		9)	
2	hould d Me mark matic	욘	Harry Forrest W  19a. Informant's Name/Relationship (T)		19b. Mailin	n Address (Street a		Pural Route Number		State. Zin	Code)
<u>8</u>	od 2 s lith an 27 is r treu		Lorraine C. Wrigh					Crownsv			
ē,	f Hea f Hea item othe	1	20a. Method of Disposition	20b. P	Place of Dispo	sition (Name of natory or other place	e)	Date	20c. Location -	City or To	own, State
Ë	Page nent o nnt: If iry or		1  Burial 2  Cremation 3  1 4  Donation 5  Other (Specify,	Removal from State		Cemetery	·	5-06	Davids	onvi]	lle, MD
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Important: If item 27 is marked eny injury or other treumatic evone.		21. Signature of Furneral Service Licente	(00)				George P. and Rd. E			
			23a. Part1. Enter the disease, or comp	lications that caused the deatl						, , ,	Approximate Interval Between
F	Physician	0 13	shock, or heart failure. List only of Immediate Cause (Final disease or condition	GLIOBU	ASTA A	na 06	= BAA	1711			Onset and Death
	/Medical		resulting in death)	Due to (or as a conseq	4	.// /(	0 1 1	210		7	
	Examiner		Sequentially list conditions,	b							
	pe iis	lner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uence of):						
	and and I-tran	Examiner	that initiated events resulting in death) Last	c. Due to (or as a conseq	uence of):					-	
8760,	icate be executed physician and s the burial-transit	dical E		A							
687	tificate ng phys as the	edlo		0.							
ŏ	eath certifi attending for use as	by Physician/Me	23b. was decedent pregnant	23c. If yes, outcome of pregna 1□Live birth 2□Feta		Ectopic pregnancy				of delive	
B	s deat he attr	sicie	in the past 12 months?	4 Pregnant at time of d		Other (specify)			Mor	nth	Day Year
о. О	that tha de led by the a detached t	Phy	9 Unknown		61 1 1			00. Bida			
rds,	8 D 0		Part II. Other significant conditions co	ntributing to death but not res	ulting in the ur	iderlying cause give	en in Part I.	23e. Did to	-/	3 Prob	ne cause of death? ably 4 Unknown
Division of Vital Record	law requir as been si 2 should	Completed						24a. Was a		Vere auto	psy findings available mpletion of cause of
č		mo.						perfor	ned?	eath?	
ita	Physicien: rthis certifici ral director,	Be (	25. Was case referred to medical examiner?				26. Place of De	eath Check only or			
5	hyslo this co	၉	1 ☐ Yes 2 <b>②</b> No		ER/Outpatien		4   Nursing	Home 5X Reside			y)
Ĕ	ing P	inol iii	27. Manner of Death  1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Work		28d. Describe ho	ow injury occurr	ed	
isi	Attending is death. ector: After by the fune.	cat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - At ho	ome farm str		Yes 2 □No	28f. Location (S	reet and Numbi	er or Rura	I Route Number
<u>&gt;</u>	s after al Dire	Certification:	4 Homicide determined	building, etc. (Specif	y)	554, 125,57, 511155		City or Town			
	To the Hospital or Attending Ph within 24 hours atten death. To the Funeral Director: After th completely filled in by the funeral	edical (	29a. Certifier (Check only one)	rsician: To the best of my kno iner: On the basis of examina and manner stated.	wledge, death	occurred at the time restigation, in my op	ne, date and place pinion, death occ	e, and due to the c curred at the time, d	ause(s) and ma ate and place, a	nner as s ind due to	tated.  the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	20		29c. License	number	2	9d. Date signed	(Month,	Day, Year)
			James	Meny MO		1000	4446	0/	06/	30/	76
			30. Name and address of person who	ompleted cause of death (Iten	n 23a) (Type.	Print Dy La	wience	Kleinhe	82 11	nn	0170/
			and to be in the	3. Registrar's Sign	10.0	ogowa	4 DUI	11440	109/10	11/6	210:01
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 0 6 20			W.					

DHMH 17 Rev 1/2001

		1	For State Registrar	State of M	Maryland / Dep Ce	artment of Hertificate of L		fental Hygien	2000	23077
	. Ye		Decedent's Name (First, Middle,	Last)				2. Date of Death		3. Time of Death
	Physicia		Dishard Willi	am Wigamar	C C C			June 2	8 2006	1415 <sup>M</sup>
	/Medic Examin		Richard Willi  4a. Facility Name (If not institution,			4b. City, Town, or	Location of Death		c. County of Deat	
	Examin	eı	Carroll Hospit	al Center		West	minster		Carro	011
5	Funeral		5. Social Security Number	3. Sex 7.	Age (In yrs. last birthda)		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Yea	9. Birt	hplace (State or Foreign
3	Director		218-72-5942	1 □ M 2 □ F	48 Yrs.	Months Days	HOUIS WILL.		1958	MD
4.7	P .	_ <b>⊢</b>	Usual Residence of Decedent		10. 0:5. Т					10d. Inside City Limits
	anylar show	.	10a. State 10b. County	13	10c. City, Town or I					1 ☐ Yes 2 ☐ No
	8e-1	Director		roll	wes	stminster		100 (	Citizen of What Co	
	vith th	ā	10e. Street and Number			10f. Zip Code		109.		uanty:
	• 234	eral	17 Golden Eagl	e Ct 12. Was Decede	nt Ever in II S 13		1158	ecify Yes or No-	USA 14. Race - Ame	rican Indian.
	ltem Trem	Funeral	<ol> <li>Marital Status</li> <li>Never Married 2 Marrie</li> </ol>	Armed Force		. Was Decedent of Hi If Yes, specify Cuba	n, Mexican, Puerto	Rican, etc.)	Black, Whit	
36	it'or	by F	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Date		1 ☐ Yes 2 No	Specify:		Specify:	White
21215-0036	within 72 hours after death with the Maryland ene. Then "raturel", or Iteme 23a or 28e-f ehow he Madical Examiner minst be notified at	De le	15. Decedent's		16a. Dec	edent's Usual Occupa	ation	16b.	Kind of Business	Industry
215	nin 73	ple	(Specify only highest Elementary/Secondary (0-12)	Grade completed)  College (1-4)	life.	e kind of work done of DO NOT use retired	) )	arig	77	
213	T. C	Completed	12			Auto Tec			Herit	age
פר	be filed tal Hygir d other event,	Be	17. Father's Name (First, Middle, L	ast)		ŀ	18. Mother's Nam	e (First, Middle, Maid	en Sumame)	
lar		10	Francis W. Wis	eman			Genev:	ieve Pulz		
Maryland	d 2 should th and Mer 7 le marke traumatic		19a. Informant's Name/Relationshi			-		al Route Number, City		
	C = M L	1	Marleen Wiseman/	wife		7 Golden E	-	Westminst		21158
ore	Sec		20a. Method of Disposition  1   Burial 2 □ Cremation	3 Pamoval from Sta	20b. Place of Dis	oosition (Name of ematory or other place	θ)	Date 20c.	Location - City or	Town, State
Ē	Pages nent of l ant: If its		4 Donation 5 Other (Sp.			Branch Cem	7/0	3/2006 W	estminst	er, MD
Baltimore,	permit. Page Department of Important: If ony injury or once.		21. Signatur uneral Service	1	•	22. Name and Address Pritts Fu	noral Lor	ne and Cha	pel, P.A	21157
	7.		23a. Part1. Enter(the disease, or o shock, or heart failure. List of	complications that cau	sed the death. Do not e	412 WaSh1 nter the mode of dying	<b>ngton Ro</b> g, such as cardiac	ad <b>Westmi</b> or respiratory arrest,	n <del>ster,</del> M	Approximate Interval Between
	Physician			nly one cause on eac			L.1.			Onset and Death
65	/Medical		disease or condition resulting in death)	a. Due to (or	as a consequence on:	iratery	7-17-14			
14	Examiner			Men	トンナンから	Synovia	failur	en in a		
€ 1		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that in the lead of the lead o	U	as a consequence of):					
	be executed sicien and burial-transit	Examiner	(nat initiated events	с						
o,	en ar		resulting in death) Last	Due to (or	as a consequence of):					
8760	hysici the bu	dlcal	9	d						
9	ng ph as th	Med	IF FEMALE:							
Вох	Physician: The law requires thet the death certificate be executed this certificate has been signed by the attending physicien and rall director, page 2 should be detached for use as the burial-transit	Physician/Me	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outco 1☐Live birt		Ectopic pregnancy			23d. Date of de Month	livery Day Year
	the att	sici	1 ☐ Yes 2 ☐ No	4□Pregnar 9□Unknow		Other (specify)				22)
P.0	thet the de ed by the detached	F.	9 Unknown		the book made and obtained in the	deabina esces and	an in Dard I	23a Did tohaco	o use contribute t	the cause of death?
	signed to	2	Part II. Other significant condition	11		underlying cause give	on an Fait i.			robably 4 Minknown
ord	w requir been si should	Completed			. • •				-	
e C	law las b	ple						24a. Was an autopsy	prior to	utopsy findings available completion of cause of
H	The rate h	00						performed 1 ☐ Yes 2	? death? No 1 ☐ Yes	2 □ No
/ita	cian: ertific actor,	Be	25. Was case referred to medical examiner?	11		104		th (Check only one)		
£	hysi this c	2	1 ☐ Yes 2 XNo	Hospital:				ome 5 Residence		ecify)
ū	After uner	ü	27. Manner of Death  1 Matural 5 ☐ Pending		Injury 28b. Time Day Year) Injury	Wor	yat k? Yes 2 □ No	28d. Describe flow in	itary occurred	
sic	tend death tor: /	cat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could n	ot be	f Injury - At home, farm,		163 2 110	28f. Location (Street	and Number or R	ural Route Number
Division of Vital Records,	or Alter of Direction by	Certification:	4 Homicide determi	ned 200. Flace of building	g, etc. (Specify)	street, lactory, office		City or Town, St		
	To the Hospital or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	ical Co	(Check only 2 Medical I	xaminer: On the bas	est of my knowledge, de is of examination and/or	ath occurred at the tin investigation, in my o	ne, date and place pinion, death occu	, and due to the cause rred at the time, date	e(s) and manner a and place, and du	s stated. e to the cause(s)
	the I	Medical	one) 29b. Signature and title of certifier	and manne	r stated.	29c. Licens	e number	29d.	Date signed (Mon	th, Day, Year)
			1 Land A	zunt. m	· P .		1552		6/30/0	
1	HC		10.00							
_	10		30. Name and address of person of the bar of Jacob	who completed cause	or death (Item 23a) (Typ	enten J	it Wa	של ינוויתלנ	in mid.	21157
	St Regist	ate rar	31. Date filed (Month, Day, Year)  JUL 0 3	2006	of death (Item 23a) (Typ	park				

	1 - For State Registrar		artment of Health and rtificate of Death	Reg. No.	2006 23078
Physician	1. Decedent's Name (First, Middle, Last)  Travis Eugene	Wells		2. Date of Death  Month Day  JULY 06	Year 2006 9:55 p M
/Medical Examiner	4a. Fecility Name (If not institution, give street and CIVISTA MEDICAL CENTER		4b. City, Town, or Location of Deat LAPLATA, MD.	h 4c.	County of Death ARLES
Funeral Director	5. Social Security Number 6. Sex 12 M 2 C	7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs Months Days Hours Min.		Birthplace (State or Foreign Country)
aryland show	Usual Residence of Decedent  10a. State 10b. County	10c. City, Town or Lo	ocation		10d. Inside City Limits
with the Mar se or 28a-f si te nutified	MD Charles  10e. Street and Number  4140 Old Washington Ro	Waldorf	10f. Zip Code 20602		zen of What Country? U. S. A.
1215-0036  1215-0036  within 72 hours after death with the Maryland ene.  then "naturel", or liems 23e or 28e-f show its Marical Exertifier must be natified at ampleted by Funeral Director	11. Marital Status 12. Was Arm	Decedent Ever in U.S. ed Forces?  Yes 2 \( \subseteq \text{No} \)	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer	Specify Yes or No- to Rican, etc.)	14. Race - American Indian, Black, White, etc.
21215-0036 ed within 72 hours at yighen. The then "natural; or the worked Exert. It. It's Muchael Exert.	3 ☑ Widowed 4 ☐ Divorced Yea	r or Dates: '42-'48   16a. Dece	dent's Usual Occupation kind of work done during most of wo DO NOT use retired)	16b. Kii	White
Ind 21215-0 be filed within 72 he tall Hygiene. to other then "natur event, its Marical	17. Father's Name (First, Middle, Last)	ege (1-4or 5+)	s Manager 18. Mother's Na	Tra: me (First, Middle, Maiden	ining Programs Sumame)
Maryland (Maryland Strong Land Strong Land Marilla My La 7 is marked other straumatic event.		t) 19b. Maili	Mary I	Lois Powell ural Route Number, City of	Town, State, Zip Code)
Baltimore, Maryland 2121 Bantimore, Maryland 2121 permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If item 27 is marked other then anny injury or other fraumatic event. Ite Mannes. To Be Comp	Sherrill A. Nee / Daug 20a. Method of Disposition 1 Removal 4 Donation 5 Other (Specify)	20b. Place of Dispo cemetery, cre	matory or other place)	Date 20c. Lo	20637 cation - City or Town, State dorf, Maryland
Balti Balti Departu Importa any inju	21. Signature of Funeral Service Licensee				nols Funl.Hme.,P. te Hall, MD 20622
ficate be executed  Wedical Examiner  The burial-transit  Medical Examiner  Medical Examiner	resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	on each line.	En i o myo pa		Approximate Interval Between Onset and Death
D = 0 %			⊒Ectopic pregnancy □ Other (specify)		23d. Date of delivery Month Day Year
rds, P.		g to death but not resulting in the to	inderlying cause given in Part I.		se contribute to the cause of death? □ No 3 Probably 4 □Unknow
Il Records, The taw requires to the tax been signed page 2 should be completed by	RENAL INSU	FFICTION		24a. Was an autopsy performed?	24b. Were autopsy findings availab prior to completion of cause o death? 1 Yes 2 No
n of Vitang Physicien: After this certification interests director.	25. Was case referred to medical examiner? 1  Yes 2 No Hospital:	1 Pinpatient 2 □ ER/Outpatie  Date of Injury (Month, Day Year)  2 □ ER/Outpatie 28b. Time of Injury	nt 3 DOA Other: 4 Nursing I	ath (Check only one)  Home 5 Residence 6  28d. Describe how injury	
Division Corte Hospital or Attending P within 24 hours after death. To the Funeral Director: After completely filled in by the funeral Medical Certification.	3 Suicide 6 Could not be determined 28e.	Place of Injury - At home, farm, st building, etc. (Specity)		28f. Location (Street and City or Town, State)	d Number or Rural Route Number, )
the Hospita in 24 hours the Funera ipletely fille	29a. Certifier (Check only one) Certifying Physician: 2 Medical Examiner: On and	To the best of my knowledge, deal the basis of examination and/or in manner stated.	th occurred at the time, date and place exercises to be a second to the control of the control o	urred at the time, date and	place, and due to the cause(s)
To the within To the comp	29b. Signature and title of certifier	\	29c. License number	29d. Dat	e signed ( <i>Month, Day, Year</i> )

		•	For State Registrar	State of Ma	ırylan	•			lealth a Death	and Me	-	giene Reg. No.	200	6 23	079
	Disconial.		1. Decedent's Name (First, Middle, L.	ast)						1	2. Date of De Month	ath Day	Yea	3. Time o	of Death
	Physicia /Medic	al	John Edw		gner	:					07	04	2004	100	6 M
	Examin	er	4a. Fecility Name (If not institution, gi		,	1-1-0	4b. City,		Location of	of Death		4c.	WICOM		
				NAL MEOICAG Sex 7. Age		last birthday)	If Under	JAH 1 Year	ff Under	24 Hrs.   1	8. Date of Bir	*b			or Comian
	Funeral Director			10 <b>X</b> M 2□F	76	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)		Birthplace (State Country)	
			Usuel Residence of Decedent								2/19/	1930		Delawar	e
0	yland	. [	10a. State 10b. County		-	y, Town or Lo								10d. Inside 0	
53	B Mai	cto	Virginia Accom	ack	Gr	ceenbac	kvil	le						1 _ Yes	S ZXNO
5-5	hours after death with the Maryland turel; or iteme 23a or 28a-f ehow al Examiner must be notified at	Funeral Director	10e. Street and Number 3774 Captains C	corridor			10f. Zip	233	56			_	zen of What ISA	Country?	
2	deat	ner	11. Marital Status	12. Was Decedent E Armed Forces?	ver in U.	.S. 13. V	Vas Dece	ent of H	ispanic Ori	gin? (Spec	ofy Yes or No lican, etc.)	)-	14. Race - Ar Black, W	merican Indian,	
ာ် မွှ	after or it	교	1 ☐ Never Married 2 ☐ MArried	1 DXYes 2 □ N If Yes, Give			I ☐ Yes					1	Specify:		
902-5	urei',	d by	3 Widowed 4 Divorced	Year or Dates:	Nav									white	
	72	Completed	15. Decedent's l (Specify only highest g			16a. Deced	lent's Usui <i>kind of wo</i> DO NOT u	rk done d	during most	t of working	g	16D. KII	nd of Busine	ss/industry	
<u>←</u> 2121	within ene. then	E C	Elementary/Secondary (0-12)	College (1-4or 5	+)	Sales						R	oofin	נ	
	Hygid Hygid Sther		17. Father's Name (First, Middle, Las	t)		Durck	, 13011	190		r's Name	(First, Middle,			,	
25 / lan	lid be lental ked c	To Be	Unknown						Ma	rgare	et Wagn	ner			
Was Ma	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 ie marked other then "naturei", or iteme 23a or 28a-1 ehow eny injury or other treumatic event, the Medical Examinar must be notified at once.		19a. Informant's Name/Relationship Joan L. Wagner/								Route Number			a, Zip Code) e , VA 23	356
> <b>5</b>	Heal Heal Heal Heal		20a. Method of Disposition		20b. P	lace of Dispo emetery, cren	sition (Na	ne of	eal	Da	ate	20c. Lo	cation - City	or Town, State	
Shw	Pages nent of int: if it		1 Ma Burial 2 ☐ Cremation 3 4 ☐ Donation 5 ☐ Other (Spec			csons (	-			7/8/0	06	Sal	isbury	, MD	
Sohw Baltimore,	permit. Departmimporta eny inju		21. Signature of Funeral Service	nsee	OJES,	<i>Q</i> 22	Holi 501	d Addresoway Snow	ss et Facilit Fune Hill	ral H	Home Pr	rofes sbury	sional	L Associ 21804	ation
			23a. Part1. Enter the disease, or conshock, or heart failure. List only	mplications that caused	the death	h. Do not ent								Approxima fntervaf Be	ate atween
	Physician		Immediate Cause (Final disease or condition	, dine cause of C	-	nas.	1 1	INF	0.0.1	1)	sea s	0		Onset and	Death
	/Medical		resulting in death)	Due to (or as		. 00 .	71	, - ,	177	101	36167	<u> </u>	<u>-</u>		
	Examiner		S - quentiafly list conditions	b											
	D #	Examiner	S quentiafy list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a curisequ	uence of).								1	
	and and	cam	that initiated events resulting in death) Last	c. Due to (or as a		uanaa af);									
8760,	le be executed ysicien and e burial-transli			Dua (0 (0) as (	a consequ	dence or).									
87	physi the t	dical		d.										1	
9 ×	death certificate be executed e attending physicien and nd for use as the burial-transit	Physician/Med	IF FEMALE:	23c. If yes, outcome	of pregna	ancy							23d. Date of	delivery	
Box	atten atten	cian	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	1☐Live birth 4☐Pregnant at	2 Feta	Ideath 3	Ectopic p						Month	Day	Year
P.O.	at the de by the a	ysi	1 □ Yes 2 □ No 9 □ Unknown	9☐ Unknown			. , ,	<i>,,</i> —							
	requires that the een signed by th nould be detache	by P	Part II. Other significant conditions	contributing to death be	ut not resi	ulting in the u	nderlying o	ause giv	en in Part I		23e. Did t	tobacco u	se contribute	to the cause of	death?
rds	quire n sig uld b										10	Yes 2	□No 3□	Probably 4 🖔	Unknown
္မ	aw require s been si 2 should I	plet									24a. Was		24b. Were	autopsy findings	s available
æ	The law cete hes b page 2 st	Completed					_				autor perfo	prmed? 2 No	death	to completion of ? es 2 □ No	cause or
ita		0	25. Was case referred to medical						26. Pface	of Death	Check only				
<b>†</b>	Physicien: r this certifice iral director, p	To B	examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatie	nt 2	ER/Outpatien	t 3□ D0	Oth Oth	er: 4 🗆 Nu	ırsing Hom	e 5 ☐ Resi	idence 6	0 □Other (S	pecify)	
0	<b>5</b>		27. Manner of Death  1 K Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year)	28b. Time of Injury		8c. Injun Wor			8d. Describe	how injur	y occurred		
Si Si	Attending r death.	cati	2 Accident investigation 3 Suicide 6 Could not	be -			М		Yes 2 🗆						
Division of Vital Records,	ofter defined Direct	Certification:	4 Homicide determine				eet, factor	y, office		28	8f. Location ( City or To			Rural Route Nu	m <i>ber</i> ,
	To the Hospital or Attendi within 24 hours efter death. ) To the Funeral Director: A completely filled in by the fu	Medical C		Physician: To the best of aminer: On the basis of and manner sta	examina										(s)
_	of the	Me	29b. Signature and title of certifier				29	c. Licens	e number			29d. Dat	e signed (M	onth, Day, Year)	
	NO.		1	M				D5:	5658	8		7	151	2006	
	VB, B		30. Name and address of person wh	o completed cause of d	eath (ften	п 23а) (Туре,							/ /	J- 7	
	17/2		FRANK J. AREA	1A, M. D	400	EASTER	NSHO	RE .	DR.	SAUS	BURY, 1	mo.	21803		
	Sta Regist		31. Date filed (Month, Day, Year)  JUL 0 7	32. Registra	ar's Signa	ature	and M	3			,				
	i legist	T T	00L 0 1		the state of	M. M.	All Property and								

_		1 - For Amend item#25,per	TIE, 66.26, 6/ 10	Ce	rtificate of	Death	2. Date of Dea	leg. No.	006	2308	80
Physic /Medi		1. Decedent's Name (First, Middle, Last) Russell Is	aac	Yates			Month  July 2,	Day	Year 6	3. Time of De 5:42	P <sub>M</sub>
Exami		4a. Facility Name (If not institution, give s 1019 Baccharis Dr			4b. City, Town, o		ath		ounty of Death		
Funeral Director		143-50-9405	7. Age	(In yrs. last birthday 51 Yrs.	Months Days	If Under 24 H		, <sub>Year)</sub> 954	Cour	place (State or F ntry) Jersey	-oreign
Maryland -f show	tor	Usual Residence of Decedent  10a. State 10b. County  New Jersey Atlan		10c. City, Town or L					1	0d. Inside City I	
with the 3e or 28e	Director	10e. Street and Number 2528 Tilton Rd.,			10f. Zip Code 08234	1		10g. Citíze	en of What Cour	ntry?	
rs after death	by Funeral		12. Was Decedent E Armed Forces? 1 ☐ Yes 2X No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cubin	lispanic Origin? an, Mexican, Pue Specify:	(Specify Yes or No- erto Rican, etc.)		Race - Americ Black, White,	etc.	
is 1 and 2 should be filed within 72 hours after death with the Maryland is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Mental Hygiene. Item 27 is marked other then "neturel", or items 23e or 28e-f show other treumatic event, the Marical Examiner must be notified at	Completed b	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation	(Give	dent's Usual Occup kind of work done DO NOT use retired	during most of w	vorking		of Business/Ind	ŕ	
ally jealing Z.I.Z. i. should be filed within and Mental Hygiene. s. marked other then "sumatic event, It e Mare	Be	17. Father's Name (First, Middle, Last) Russell Yates Sr.		LLC	ер соок	18. Mother's N	ame <i>(First, Middl</i> e, a (unkn	Maiden S		<u> </u>	
y INICILY COLLONGRAM  and 2 should be file salth and Mental Hy n 27 is marked oth er treumatic event	To	19a. Informant's Name/Relationship (Ty Teresa Yates/wife	pe, Print)			and Number or i	Rural Route Number	r, City or T			
permit. Pages 1 and 2 Department of Health Importent: If item 27 I any injury or other treasons.		20a. Method of Disposition  1 Burial 2 Coremation 3 F  4 Donation 5 Other (Specify)	emoval from State		osition (Name of matory or other place y Cremato	•	Date /6/05		isbury,		
Dermit. Departn Importe any inju		21. Signature of Funeral Service Liurns	eenly (7	The second secon	Name and Addre	ss of Facility Funeral	Home Pro	fess	ional As	ssociat	ion
Filysician /Medical Examiner	ner	23a. Part 1. Enter the disease, or complishock, or heart failure. List only or immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):	ter the mode of dyir	ig, such as cardi	ac or respiratory an	rest,		Approximate Interval Betwee Onset and Dea	
certificate be executed inding physician and ise as the burial-transit	Ilcal Examiner	that initiated events resulting in death) Last		consequence of):							
death e atter	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	Fetal death 3	□Ectopic pregnance	/		23	d. Date of delive Month	ery Day Yea	ar
w requires that the been signed by the should be detached	by	Part II. Other significant conditions con	ntributing to death but	t not resulting in the	underlying cause giv	en in Part I.		bacco use es 2 🗆	e contribute to the		
N 0 0	Completed						24a. Was a autop perfor	sy med?	24b. Were auto prior to con death? 1 \( \sum \text{Yes}	mpletion of caus	ailable se of
To the Hospitel or Attending Physicien: The law requirest within 24 hours after death.  To the Funerel Director: After this certificate has been signed completely filled in by the funeral director, page 2 should be on	Certification; To Be	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	lospital: 1 ☐ Inpatien  28a. Date of Injury (Month, Day)		of 28c. Injur War	er: 4 \_ Nursing	eath (Check only or Home 5 Resid 28d. Describe h	ence 61 ow injury	occurred	ome of	ugh
spitel or A			building, etc.	. (Specify)  f my knowledge, dea	th occurred at the ti		City or Tow	n, State) cause(s) a	nd manner as si	tated.	
To the Ho within 24 the To the Fui	Medical	(Check only 2 Medical Examione)  29b. Signature and title of continue	nar: On the basis of and manner stat		29c. Licens		2		signed (Month,	Day, Year)	
1900		30. Name and address of person who considered and some series of person who considered and series of p			, Print)			01	, , ,	-	

ORIGINAL

			For State Registrar	State of I	Marylan	•	artmen rtificat					Reg. No.	006	23081
** 5	Physicia	ın	Decedent's Name (First, Middle, Last  Evan Powell		· ~						2. Date of Dea Month	Day	Year	
	/Medic	al	4a. Facility Name (If not institution, give				4h City	Town or	Location	of Death	July		2006 ounty of De	11:00 a M
	Examin	CI	273 Blue Heron Dri		<del>0</del> 1)				nster			10.0	Carr	
	Funeral	ilit.	Social Security Number 6. S	х 7.	Age (In yrs.	last birthday)	If Under	r 1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day	Year)		irthplace (State or Foreign Country)
18. Tay	Director		213-22-1003	□M 2□F	80	Yrs.	WIOTILIS	Days	Tiours	IVIIII.	Aug 30,	1925	Ma	ryland
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	y, Town or Lo	cation							10d. Inside City Limits
	Manyla 1 sho	ō	Maryland Carro	11				1	Westn	ninst	er			1 ☐ Yes 2 No
	r 28a	irec	10e. Street and Number				10f. Zig	Code				-	n of What (	Country?
	within 72 hours after death with the Maryland ene. than "naturel", or itema 23a or 28a-f show tha Madical Expressional be motified at	by Funeral Director	273 Blue Heron Dri	.ve					211				JSA	
	tems rems	ner	11. Marital Status	12. Was Decede Armed Force	es?	.S. 13.	Was Dece If Yes, spe	dent of Hi cify Cuba	spanic Or n, Mexicai	rigin? (Sp n, Puerto	ecify Yes or No- Rican, etc.)	14	Race - An Black, Wh	nerican Indian, nite, etc.
36	s afte	y Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	1X Yes 2 If Yes, Give Year or Date	TATATE T		1 🗆 Yes	<b>2√2</b> No	Specify:	:		8	pecify: \	white
웅	2 hou	ed	15. Decedent's Ed	ucation		16a. Dece	dent's Usu	al Occupa	ation			16b. Kind	d of Busines	ss/Industry
215	hin 72	ple	(Specify only highest grade Elementary/Secondary (0-12)	fe completed) College (1-4	or 5+)		kind of wo DO NOT u			st of work	ing		Hospi	tal
Maryland 21215-0036	filed wit Hygiene other the	Completed	7		·	IV.	ainte	enanc						
and	tal Hy	Be	17. Father's Name (First, Middle, Last)  Evan Powell Zepp								e (First, Middle, Hallbro		umame)	
7	should be and Mental I marked o	ဌ	19a. Informant's Name/Relationship (7	ivne Print)		19h Maili	na Address	s (Street			ral Route Numbe		Town State	Zin Code)
Ma	d 2 sho	1	Roger L. Zepp, son	ype, rrang			_				Westmir			
ē,	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Heelth and Mental Hygiene. If item 27 is marked other than "naturel", or itema 23a or 28a-f show or other traumatic event, the Madical Examiner must be invitined at		20a. Method of Disposition		20b. F	Place of Dispo cemetery, crea	osition (Na	me of other plac	e)		Date	20c. Loc	ation - City o	or Town, State
E	Page net o int: if		Unit Surial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from Sta )	ete Ev	ergree	n Men	noria	í (	07/08	3/2006	Fin	ksburg	g, MD
Baltimore,	permit. Pages 1 and 2 Department of Heelth s Important: If item 27 is ony injury or other tra		21. Sig. ature of Funeral Service Licen	993			2. Name a							eral Home
<u> </u>	80 5 5 8		Justin K	Jul	raron						Westmir		, MD 2	
			23a. Part1. Enter the disease, or come shock, or heart failure. List only of	olications that cau one cause on eac	ised the deat th line.	h. Do not en	ter the mod	de of dyin	g, such as	scardiac	or respiratory ar	rest,		Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a		PJ	7							
ļ.,,	Examiner		1	Due to (or	as a consec	uence or):								
		Jer	Sequentially list conditions, if any, leading to immediate	Due to (or	as a conseq	uence of):	Λ		_					
	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	。C	mor		HK	rial	4	bri	llation			
760,	e exe zien a urial-l	EX	resulting in death) Last	Due to (or	as a consec	.80	Sta	0.						
6876	cate b	dicai		d	Ca	I Vi	7-1-4	40						
9 X	ding I	/Me	IF FEMALE:	23c. If yes, outco	me of pregna	ancy						23	d. Date of c	lelivery
Вох	death atter	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	4 Pregnar	h 2 ☐ Feta nt at time of c		□Ectopic p □ Other (s						Month	Day Year
0	t the c by the achec	hysi	9 Unknown	9□ Unknow	m									
S, D	s tha	by Physician/Medi	Part II. Other significent conditions of	ontributing to dea	th but not res	sulting in the u	inderlying	cause giv	en in Part	1.				to the cause of death?
Records,	equire en sig	ted									101	′es 2 🗆	No 3⊕	Probably 4 □Unknown
ec C	law r las be	Completed									24a. Was autop	sy	prior t	autopsy findings available o completion of cause of
= H		Con										rmed?	death'	es 2 No
Vital	sician: The law certificate has t irector, page 2 s	Be	25. Was case referred to medicat examiner?	Hospital:				OA Oth	or.		th (Check only o			
Þ	Phys this ral dir	2	1 Yes 2 146	1 Ing		ER/Outpatie		OA Injur	4 🔲 14	ursing Ho	28d. Describe			pecify)
on	ding th: After	tion	1 Datural 5 Pending 2 Accident investigation	(Month,	Day Year)	Injury	м	Wor	k? Yes 2 □	]No		,		
Division	Attendi r death. ector: A by the fu	iffica	3 Suicide 6 Could not be determined	28e. Place of		ome, farm, st	reet, factor	ry, office			28f. Location (S City or Tox		Number or	Rural Route Number,
Ö	s afte el Dir	Certification:	4   Homode	Dulloning	, etc. ( <i>Speci</i>						City or You	nt, State)		
	Hospitel or Attending Physician: 4 hours after death. Funerel Director: Alter this certification by the funeral director, tely filled in by the funeral director.		29a. Certifier 1 Certifying Ph											
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funerel Director: After this certific completely tilled in by the funeral director,	Medical	one) 29b. Signature and the of certifier	and manne					e number					nth, Dey, Year)
	T W F O			ΛΛΟΛ	M	17				54	218	05	7-0	5-06
-	work and	5	30. Name and address of person who	completed cause	of death (Ite	m 23a) (Type	, Priot)	4		J	-(0	-		
	5416		30. Name and address of person who	B Kan	eua,	349	Ma	lca	Im c	elu	m, we	rtn	1) when	MD 2115M
100	the Ch	ite	31. Date filed (Month, Day, Year)	32 / Reg	gistrar's Sign	ature								-

EVAN P. ZEPP, JR.

State of Maryland / Department of Health and Mental Hygiene For State Ragistra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Physician ARRINGTON OPHELIA Τ., 07 17 06 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner BAYVIEW MEDICAL CENTER BALTIMORE 8. Date of Birth (Month, Day, Year) AUG. 26, 1952 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) **Funeral** Min. Months Days Hours 1 M 2 F Yrs 53 MD. Director 215 56 2745 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits or items 23a or 28a-f show the Mudical Exactines must be notified at 1 ☐ Yes 2 ☐ No MD. N/A BALTIMORE Directo 10e. Street and Number 10f Zin Code 10g, Citizen of What Country? 3036 MAYFIELD AVENUE 21213 usa death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: BLACK 1 ☐ Yes 2X No Specify: ģ 3 Widowed 4 Divorced "natural", Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12TH HOUSEKEEPER BROADWAY SERVICES other 1 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked other any injury or other traumatic event plies. 18. Mother's Name (First, Middle, Maiden Sumame) Be ROBERT LEE MC MILLAIN GERALDINE HESTER 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3036 MAYFIELD AVE. BALTO, MD. 21213 SHERYL GOLDMAN (daughter) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 🙀 Burial 2 □ Cremation 3 □ Removal from State Donation 5 Other (Specify) KING MEM. PK. JULY 24, 2006 BALTO, MD. Signature of Funeral Service Licensee 22. Name and Address of Facility CALVIN B. SCRUGGS FUNERAL HOME 1412 E. PRESTON ST. BALTO, MD. 2121323a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PROBABLE STRS **Physician** /Medical Due to (or as a consequence of) Examiner ENCRIMALOPATHY WITH SEZIULE DESCRIP ANOXIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed MDA attending physician and Due to (or as a consequence of) Box 68760. Physiclan/Medical the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy detached for in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) Ö 9 Unknown 9 Unknown ፩ Division of Vital Records. P. signed l Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 4 Olynknown 1 ☐ Yes 2 ☐ No 3 Probably Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an certificate 30 No 1 Yes : After this certifical funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: ¥Yes 2 No 1 Inpatient **ER/Outpatient** ဥ 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending investigation death. 1 Yes 2 No Director: / 2 Accident 3 Suicide 6 Could not be Place of Injury - At home, farm, street, faclory, office building, elc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Dire 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 120/06 address of person who completed cause of death (Item 23a) (Type, Print) nth, Day, Year) 31. Date Registrar's \$ignalure State JUL 2 4 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item 20b per fn 885/7-24-06 vt

			1 - For State Registrar	State	f Maryla		artment rtificate				lental Hy	giene Reg. No.?	006	23083
	Dhoole		1. Decedent's Name (First, Middle,	Last)					-		2. Date of De	ath	_ <del></del>	3. Time of Death
н	Physici /Medio		Joan Lorett	a Bl	lackburi	n					Month	Day ZZ	Z006	Z:28 PM
	Examir		4a. Facility Name (If not institution,			•	4b. City, To	wn, or	Location o	of Death	41/		ounty of Death	
			Union Memorial	Hospital			Balt	imo	ro					
	Funeral			S. Sex		. last birthday)	If Under 1	Year	If Under :		8. Date of Bir	th .	9. Birthr	place (State or Foreign
	Director		215-46-9819	1 □ M 2 🔀 F	58	Yrs.	Months I	Days	Hours	Min.	(Month, Da 3/15/1	ay, Year)	Mary	ntry)
	79		Usual Residence of Decedent								3/13/1	940	Mary	Tanu
	ylan		10a. State 10b. County		10c. C	ity, Town or Lo	cation						1	0d. Inside City Limits
	Mar	ģ	Maryland Baltin	nore	PO	sedale								1 ☐ Yes 2 📉 No
	28s	Director	10e. Street and Number	IOLC	110.	<u>scaarc</u>	10f. Zip C	ode				10g. Citize	n of What Cour	ntry?
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	leath	Funeral	5365 King Arthu		edent Ever in I	IS 13 1	2123		nanie Orie	nin2 (Sne	city Yes or No	U. S	. Race - Americ	an Indian
	iter of	Ë	1 ☐ Never Married 2 Marrie	Armed Fe	orcęs?		f Yes, specify	Cuban	, Mexican	Puerto	Rican, etc.)	,-   '-	Black, White,	
ဗ္ဗ	irs a	b	3 ☐ Widowed 4 ☐ Divorced	If Yes, Gi Year or D	ve		l∐Yes 2∭X	No	Specify:			S	pecify: r	4 L _
21215-0036	72 hours after death with the Maryland Instural; or iteme 23a or 28e-f show dical Examinar must be notified at	ed	15. Decedent's			162 Door	lent's Usual (	200000	tion			105 16:04		ite
15	in 72	Completed	(Specify only highest	grade completed)		(Give	kind of work OO NOT use	done di retired)	uring most	of worki	ng		of Business/Inc	austry
2	the end	Ĕ	Elementary/Secondary (0-12)	College (	1-4or 5+)			.01,,00,				Auto	mobile.	
7	filed Hygi Ither int,		17. Father's Name (First, Middle, La	251)		Super	VISOL		10 Mother	da Nama	(First, Middle		facturi	ng
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Ž	1 Me Jark	ပ္	Charles Milto		ın		1,00		Grac		Lorett		ain	
Maryland	2 st		19a. Informant's Name/Relationshi										own, State, Zip	
<u>~</u>	and lealth III 27 her t		Larry Blachburr	ı (Husbar		5365	King	Art	hur C			edale	, Maryl	and 21237
9	of H		20a. Method of Disposition	Removal from		Place of Dispo cemetery, cren	sition (Name natory or othe	of or place	)	D	7/25	20c. Loca	tion - City or To	wn, State
Ē	Pag ment ant: ury c		4 □Donation 5 □Other (Spe			llv Hil	l Memo	ria	l Gar	dens	20076	Midd	le Rive	r, Maryland
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or iteme 23a or 28a-f show any injury or other traumatic event, the Madical Exportment must be notified at 200ce.		21. Signature of Funeral Service Li	censee							Home :			-,
Ω	8958		Muchael C. Jo	Show Sr	7	1	407 OI	d E	aster	n Av	nome : Tenue	PA Essex	. Marvla	and 21221
			23a. Part 1. Enter the disease, or	mplications that of	aused the dea	th. Do not ente	er the mode of	f dying	such as c	cardiac o	respiratory a	rrest,	,	Approximate
	Physician		shock, or heart failure. List or Immediate Cause (Final			1	, -	> .						Interval Between Onset and Death
<b>`</b>	/Medical		disease or condition resulting in death)	a	Corona	iry Mr	tery 1	(54	456					Zyenrs
	Examiner			546 10	Corona (or as a consec My o	quence on.	1 1.0		/•					Zdans
		ē	Sequentially list conditions, if any, leading to immediate	b. — Due to	(or as a consec	Quence of):	174	crc	ton					2 005
	pet nsit	Examine	cause. Enter Underlying Cause (Disease or injury											
	xecu al-tra	Xai	that initiated events resulting in death) Last	c	(or as a consec	quence of):				-				
58760,	ficate be executed physicien end is the burial-transit	a												
387	icate phys	dical		d										
_	death certifi e attending p id for use as	ME	IF FEMALE:	23c. tf yes, out	come of prean	ancy								
Box	atten for u	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live b	irth 2 Feta	aldeath 3□	Ectopic pregr					230	<ol> <li>Date of delive Month</li> </ol>	ry Day Year
	0 00 0	Sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4⊟ Pregn 9⊟ Unkn	ant at time of o	death 5∟	Other (speci	fy)						ou, cui
<u>.</u>	hat ti d by detac	급	Part II. Other significant condition	e anatribution to di										
Division of Vital Records,	iaw requires that the as been signed by th 2 should be detache	þ	Tarris other significant condition	s contributing to di	Baut Dut not 195	suiting in the un	denying caus	e given	in Parti.					a cause of death?
2	w requir been s should	Completed									101	′es 2□N	lo 3 Proba	ably 4 □Unknown
ပ္	as b	e d									24a. Was	an 2	4b. Were autop	sy findings available aptetion of cause of
I	The lav	E O										rmed?	death?	
<u> </u>	ician; Th certificate ector, pag	0	25. Was case referred to medical		1	_	-		26 Place	of Death	1 ☐ Yes (Check only o	200 No	1 🗆 Yes	2 LI NO
>	ysicia is cert direct	0	examiner? 1 ☐ Yes 2 ② No	Hospital:	npatient 2	ER/Outpatient	3□ DOA	Other				-	Other (Specify	
5	y Phys er this eral di		27. Mann of Death	28a. Date	of Injury	28b. Time of		Injury a	at		3d. Describe h			
5	th. : After s funer	윤	1 ✓ Natural 5 ☐ Pending 2 ☐ Accident investigat		th, Day Year)	Injury	м	Work? 1 □ Ye	s 2∐N					
<u>s</u>	Attending Physician: r death. sctor: After this certifice by the funeral director.	‡ Lea	3 ☐ Suicide 6 ☐ Could no	be 200 Diago	of Injury - At h	ome, farm, stre	et factory of				Rf Location (S	Street and N	lumber or Rural	Pouts Number
É	F 5 F C	Certification;	4 Homicide	buildi	ng, etc. (Specia	fy)	,				City or Ton	n, State)	uniber of Mulai	Aobie Williber,
	spita ours nerai	2	29a. Certifier 1 Certifying	Physician: To the	hest of my kno	nwladaa daath	occurred at t	ho timo	date and	place o	and alors an above			
	P Fur	edical	one) 2 Medical Ex	annition. On the be	asis of examina	ation and/or inv	estigation, in	my opir	non, death	occurre	d at the time.	tate and pla	ice and due to	the cause(s)
	To the Hospital of within 24 hours af To the Funeral D completely filled in	Me	29b. Signature and title of certifier				29c. Li	cense r	number			29d. Date si	igned (Month C	Nav Yearl
	- × - ŏ			is 7 V	1/2	. 010	4	1/2	438	941	1110	1.7	79 7	. / -
			cerce	470	X	7	/	1	170	70	- 2-20	247	12,00	6
	10		30. Name and address of person who CECILIA WAN	o completed caus	e of death in a	n 23a) (Type, F ムレ 1/14	rint)	<u></u>	Park.	lac-	Bell	MOVA	Monda	pay, Year) p 6 and Z1Z18
	- 64-		31. Date filed (Month, Day, Year)	32	gistrar's Signs	ature 4	, , , , , ,	2	INIFA	Can	114171	11.014	ז וותוקום	no ordig
	Star Registra		1111 2 4	2006	latina o origina	H. do	ade							

# Please Type or Print in Black Indelible Ink

Theresa Baldwin	. F	- For State Registrar				epartment Certificate			ental Hy	Re	eg. No. 20	06 2308
Physicia Medical Examir	-	1. Decedent's Name (I								2. Date of Deat Month July 19, 20	Day Year	3. Time of Death 1020 hrs
		4a. Facility Name (if n	ot institution, g	ive street and r				Town, or Locat	ion of Death	ou.y , o, _	4c. County of De	
Funeral		Baltimore Was  5. Social Security Num		Sex		rs. last birthday		Burnie der 1 Year   If U	Under 24Hrs.	8. Date of Birt	Anne Aruno	Birthplace (State or
Director		579-94-986	55 1	M _ 2 X F	55		Yrs. Montl	hs Days H	lours Min.	SEPT.	11, 1950	PASHINGTON, Country) D.C.
any		Usual Residence of De 10a. State 10	ecedent b. County		10c (	City, Town or Lo	ocation					10d Inside City Limits
and f show	٥	MARYLAND A		UNDEL		SEVERN						1 Yes 2 X No
e Mary	Director	10e. Street and Numb					10f. Zip	c Code			og. Citizen of What (	
with th		233 SEVERN			ecedent Ever i	in U.S. 13.	Was Deced	ent of Hispanic		ecify Yes or No-		nerican Indian, Black,
r death	Funeral	1 X Never Married		1 Yes	2 X N	lo		ify Cuban, Mex		Rican, etc.)	White, etc	HITE
urs afte tural",		3 Widowed  15. Decedent's Educ		ed If Yes, Give Your Dates: only highest gra			dent's Usua	No spe	Sive kind of w		Specify: W	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mernal Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f show injury or other tranmatic event, the Medical Examiner must be notified at once.	Completed by	Elementary/Second	dary (0-12)	College	(1-4 or 5+)		g most of wo	orking life. DO N	NOT use retir	red)	N/A	
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	S S	17. Father's Name (Fi	rst, Middle, La	st)			110000	18.Mc	other's Name	(First, Middle, M	Maiden Surname)	
121 Id be fill Aental F narked event,	Be	CARL GIBE				19h Ma	ulina Addres			ZZULLO	ber, City or Town, S	rate Zin Code)
MD 2 d 2 shou lith and M n 27 is n aumatic	$\vdash$	MARY BALDW						,				YLAND 20758
ore, I	Ī	20a. Method of Dispos 1		3 Removal	from State		r other place	)	JUL	Date Y 21,	20c. Location - City	or Town, State
Baltimore, permit. Pages I ar Department of He Important: If ite	-	4 Denation 5	Other Spec		1	4ETRO CI				06		LLE, MARYLAND
Ba perm Depa Imperinjur		Aday	lix	011000			KIRKLE 421 CF	EY-RUDD RAIN HW	ICK FUY., S.	NERAL H E., GLE	OME, P.A. N BURNIE,	MD 21061
Physician /Medical		23a. Part I. Enter the of failure. List only	one cause on	each line.		eath. Do not ent	er the mode	of dying, such	as cardiac or	respiratory arre	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Fir or condition resulting		Due to (or as		ce of):						Death
	-i-	Sequentially list condi		b. Due to (or as	a consequen	ce of):						
	Examiner	cause Enter Underly (Disease or injury that	ring Cause t initiated	c. Due to (or as								
ecuted and transit		events resulting in de		d	a conocquen				·-···			
60, ate be exe hysician a	Medical	UNPENDED		AMENDED								
5876 ortificate ding phy		IF FEMALE: 23b, Was decedent pre past 12 months?	egnant in the	1 Live	, outcome of p birth	2	Fetal death	3Ec	topic pregna	ncy	23d. Date of deline Month	very Day Year
Box 687 e death certific the attending p	ysician/	1 Yes 2 No	9 Unkno		inant at time o nown	of death 5	Other (Spe	ecify)				
O. Box 68760, that the death certificate be expedited by the attending physician detached for use as the burial.	by Phys	Part II. Other signific	ant condition	s contributing	to death but r	not resulting in t	he underlyin	g cause given i	in Part I			to the cause of death?
ords, P.O.   w requires that the as been signed by t										24a Was a		Probably 4  Unknown autopsy findings available
tal Records cian: The law requi certificate has been ector, page 2 should	Completed									autops perfor	sy prior med? death	to completion of cause of ?
Vital Roysician: The certifical director, pa	BeC	25. Was case referred examiner?	to medical					26.Place of De				163 2 100
of Vit ing Physic After this c	리	1 ✓ Yes 2 27. Manner of Death	No	Hospital: 1	Inpatient 2 e of Injury	ER/Outpat		DOA Other	T THE ON I		Residence 6 O	her
	Certification:	1 Natural	5 Pending	Jul 19,	th Day Year) 2006	0915 hrs		1 Yes 2			ght in safety stra	ар
Nivision I or Attencather death Director:	tific	3 Suicide	Could n	ot be 28e. Pla		At home, farm,	street, factor	y, office buildin		or Town, St	tate)	Rural Route Number, City
Di To the Hospital. Within 24 hours a To the Funeral I		4 Homicide 29a. Certifier 1 Ce			() Group I est of my know		ccurred at th	e time, date an			Rd, Millersville, e(s) and manner as s	
Divisior  To the Hospital or Attend within 24 hours after death To the Funeral Director:	Medical	one) 2 M		ner: On the basis and manner	of examination of exa	on and/or inves				t the time, date a	and place, and due to	
7	2	29b. Signature and titl	ie or certifier	112	/· 1/			O.C.M.E.	IDEI		29d Date signed ( July 20, 2006	wonth, ∪ay, Year)
7		30. Name and address	s of person wh		2	Item 23a	u V		_			
2		Theodore M.		_	tant Medic	al Examiner	111 P	enn Street,	Baltimore	e, MD 21201		
St Regist	ate .rar	31. Date filed (Months	11 24	2006	Esta-	B	Local.	7				

DHMH 17 Rev 1/2001 OCME 2006

ORIGINAL

Alexander Bousquet

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State C6	ertificate o	f Death		Re	eg. No 200	5 2308
Physicia	an/	1 Decedent's Name (First, Middle,Last)				Date of Deat     Month		3. Time of Death
edical Exami	ner	Alexander Bousquet				July 19, 20	006	0941 hrs
		Facility Name (if not institution, give street and number)     Intersection of Rt. 210 and Fort Washingt		4b. City, Town, Fort Was	or Location of Dea	ath	4c. County of Deat Prince Georg	
		5. Social Security Number 6. Sex 7. Age (In yrs.	Lost highdow	If Under 1 Y		Iro Q Data of Dir	th(MM/DD/YYYY) 9. Bi	
Funeral Director				Months D		lin.	Forei	gn
		043-86-7889 1X*M 2 F 16	Yrs	S.		Nov 8,	1989	ountry) CT
any		Usual Residence of Decedent  10a. State 10b. County 10c, Cit	y, Town or Locat	tion				10d Inside City Limits
À								1XX Yes 2 No
Maryland 28a-f show	cto	CT New London Co	lchester	10f. Zip Code		I 10	Og. Citizen of What Cou	untry?
or 28	Director	144 Old Hebron Road		0641				,
vith th s 23a e noti		11 Marital Status 12. Was Decedent Ever in	U.S. 13. W			Specify Yes or No-	USA - 14. Race - Amer	rican Indian, Black,
eath v item ust b	uneral	1 XX Never Married 2 Married Armed Forces? 1 Yes 3x No			oan, Mexican, Pue		White, etc	
fter d F. or	ш	3 Widowed 4 Divorced If the second of the se	1	Yes 2xx	No specify		Specify Wh	nite
ours a atura camin	d by	15. Decedent's Education (Specify only highest grade completed)			pation (Give kind o		16b. Kind of Business	/Industry
Cal E	Completed	Elementary/Secondary (C-12) College (1-4 or 5+)	auring in	lost of working i	ire. DO NOT use r	etirea)		
15-0036 iled within 72 Hygiene d other than '	Ę	11	Stu	ıdent			Windham	Tech
filed Thyga	Ö	17. Father's Name (First, Middle, Last)				me (First, Middle, N	Maiden Surname)	
21215-0036 uld be filed within 7 Mental Hygiene marked other than	00	Gary Bousquet  19a. Informant's Name/Relationship (Type, Print )	Ligh Mailin	a Addross (St	Linda I		nber, City or Town, State	7.0.4.
MD 21215-0036 d 2 should be lifted within 72 hours after death with the Maryland that and Monda I Hygien with 17 hours after death with the Maryland in 27 is marked other than "natural", or items 23a or 28a-f shu numatic event, the Medical Examiner must be notified at once	٩							s, zip Gode)
두 명품 등 종 .		Linda Strickland Mother  20a. Method of Disposition 20b	. Place of Dispos	sition (Name of	Rd, Colche	Date	06415 20c Location - City or	Town, State
Baltimore, MD 2 permit Pages 1 and 2 shou Department of Health and I Important: If item 27 is r injury or other traumatic		1 XXBurial 2 Cremation 3 Removal from State	crematory or ot w Hebron	ther place) Cemetery	Jui	ly 26, 2006	Hebron, CT	
Baltimore permit Pages 1 Department of 1 Important: If		4 Donation 5 Other Specify:		Name and Addr				
Ba Perm Depre Imp		K. Gregory (Nink M01148		Fink Fund	eral Home,	P.A. en Burnie,	MD 21061	
Physician		23a. P. T. I Enter the diseale, or complications that caused the deal failure. List only on cause on och line.	h. Do not enter t	the mode of dyir	ng, such as cardia	or respiratory arre	est, shock, or heart	Approximate Interval
/Medical		Immedia Cause (Final disease a. Multiple Injuries						Between Onset and Death
Examiner		or condition resulting in death)  Due to (or as a consequence	of):					
	<u>.</u>	Sequentially list conditions, b.	-1)					
	i.	if any, leading to immediate Due to (or as a consequence cause. Enter Underlying Cause	OI).					
A = #	Examiner	events resulting in death) Last Due to (or as a consequence	of):					
evecuted an and al-trans		d						
760, cate be exe physician a	Physician/Medical	UNPENDED AMENDED						
3760, ificate be ig physic s the bur	Ž	IF FEMALE: 23b Was decedent pregnant in the		atal death	3 Ectopic preg	inancy	23d. Date of deliver Month	y Day <b>Y</b> ear
Box 687  e death certifithe attending ed for use as t	icia	past 12 months?	dooth	ther (Specify)	- Catabia bias	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	A	July 100.
Bo e deat the at ed for	hys	1 Yes 2 No 9 Unknown 9 Unknown						
P.O. B s that the d gned by the e detached	by P	Part II. Other significant conditions contributing to death but not	resulting in the	underlying caus	e given in Part I.		bacco use contribute to	
ords, P.C w requires that is been signed be should be deta						-	2 <b>V</b> No 3 Pro	,
cord law req has bee 2 shou	Completed	<u> </u>				24a Was a autop	sy prior to	utopsy findings available completion of cause of
Rec The la	E					perfor		es 2 No
tal Rec	Be	25. Was case referred to medical examiner?		26.Pla	ace of Death (Ched	ck only one)		
of Vital Records, g Physician: The law require the this certificate has been si neral director, page 2 should b	ToF	1 ✓ Yes 2 No	ER/Outpatient				Residence 6 🗸 Othe	r: Scene
1 of Iing Pi After funera	ä	27. Manner of Death  1 Natural 5 Panding Jul 19, 2006	28b. Time of 0905 hrs		njury at Work?		now injury occurred auto auto collision	
ivisior or Attencafter death Director:	ati	2 Accident Investigation			Yes 2 V No			
Division tal or Attendir rs after death al Director: A	Certification;	3 Suicide 6 Could not be determined (Specify) Major Po			e building, etc.	or Town, S	tate)	ural Route Number, City
id spi		4 Homicide  29a. Certifier 4 Continue Physician To the best of my knowledge.			data cond -1	<u> </u>	Rt 210 and Fort V	
To the Ho within 24 h To the Fu	ica	(Check only one) 2 Medical Examiner: On the basis of examination						
To with	Medical	and manner stated  29b. Signature and title of certifier			ense number		29d Date signed (Mo	
		7.6.111011		0.0	C.M.E.		July 20, 2006	
,		30. Name and address of person who completed cause of death (Ite	m 23a)		- · · · · · · · · · · · · · · · · · · ·			
4		Zabiullah Ali, M.D. Assistant Medical Examine		nn Street, Ba	altimore, MD 2	21201		
S	tate	31. Date filed (Month. Day Year) 000 32, Registrar's Signs	fture	11. 1				
Regis		JUL 2 4 2000	ASS ASSESSED					

1. Decedent's Name (First, Middle, Last)  Physician   Medical   JOANNE   BRISCOE    1. Decedent's Name (First, Middle, Last)   2. Date of Death Month   Day Year   18 2006    Examiner   4a. Fecility Name (If not institution, give street and number)   4b. City, Town, or Location of Death   4c. County of Death   4c. County of Death   4d. County of Death	3. Time of Death  3:37 PM
/Medical JOANNE BRISCOE	13.31P
ST. AGNES HOSPITAL BALTIMORE N/A	
	lace (State or Foreign htry)
Usual Residence of Decedent	YLAND
10a. State 10b. County 10c. City, Town or Location	0d. Inside City Limits
MD. N/A BALTIMORE  106. Street and Number 106. Zip Code 10g. Citizen of What Coun	1 XYes 2 No
10g. Citizen of What Countries 2818 W. LAFAYETTE AVE.	itty?
The second secon	
Ammed Forces?    Ammed Forces?   If Yes, specify Cuban, Mexican, Puerto Rican, etc.)   Black, White, or the specify Cuban, Mexican, Puerto Rican, etc.)   Black, White, or the specify Cuban, Mexican, Puerto Rican, etc.)   Black, White, or the specify Cuban, Mexican, Puerto Rican, etc.)   Black, White, or the specify Cuban, Mexican, Puerto Rican, etc.)   Black, White, or the specify Cuban, Mexican, Puerto Rican, etc.)   Black, White, or the specify Cuban, Mexican, Puerto Rican, etc.)   Black, White, or the specify Cuban, Mexican, Puerto Rican, etc.)   Black, White, or the specify Cuban, Mexican, Puerto Rican, etc.)   Black, White, or the specify Cuban, Mexican, Puerto Rican, etc.)   Black, White, or the specify Cuban, Mexican, Puerto Rican, etc.)   Black, White, or the specify Cuban, Mexican, Puerto Rican, etc.)   Black, White, or the specify Cuban, Mexican, Puerto Rican, etc.)   Black, White, or the specify Cuban, Mexican, Puerto Rican, etc.)   Control of the specific Rican, etc.	etc. ACK
MD. N/A  BALTIMORE  10e. Street and Number  2818 W. LAFAYETTE AVE.  11. Marital Status  11. Marital Status  11. Marital Status  11. Mere Married 2 Married  3 Widowed 4 Divorced  15. Decedent's Education  (Specify only highest grade completed)  15. Decedent's Education  (Specify only highest grade completed)  16a. Decedent's Usual Occupation  (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Inc.  16b. Kind of Business/Inc.  16b. Kind of Business/Inc.  17c. Decedent's Usual Occupation  (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Inc.  16b. Kind of Business/Inc.  16c. Decedent's Usual Occupation  (Give kind of work done during most of working life. DO NOT use retired)  16c. Decedent's Usual Occupation  (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Inc.  16c. Decedent's Usual Occupation  (Give kind of work done during most of working life. DO NOT use retired)  16c. Decedent's Usual Occupation  (Give kind of work done during most of working life. DO NOT use retired)  16c. Decedent's Usual Occupation  (Give kind of work done during most of working life. DO NOT use retired)  16c. Decedent's Usual Occupation  (Give kind of work done during most of working life. DO NOT use retired)  16c. Decedent's Usual Occupation  (Give kind of work done during most of working life. DO NOT use retired)  16c. Decedent's Usual Occupation  (Give kind of work done during most of working life. DO NOT use retired)  16c. Decedent's Usual Occupation  (Give kind of work done during most of working life. DO NOT use retired)  16c. Decedent's Usual Occupation  (Give kind of work done during most of working life. DO NOT use retired)	
15. Decedent's Education (Specify only highest grade completed)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Included life. DO NOT use retired)	333.7
NURSES ASSISTANT HEALTHCAR	E
Tr. Father's Name (First, Middle, Last)  CARL KELLY SR.  18. Mother's Name (First, Middle, Maiden Sumame)  LILLIE MAE BROWN	
The part of the pa	Code)
≥ per ROBERT W. BRISCOE JR(HUSBAND) 2818 W. LAFAYETTE AVE. BALTIMORE, MARYLA	
ROBERT W. BRISCOE JR(HUSBAND) 2818 W. LAFAYETTE AVE. BALTIMORE, MARYLA  20a. Mannod of Disposition  1 Burial 2 Cremajion 3 Removal from State  4 Donation /5 Other (Specify)  20b. Place of Disposition (Name of cemetery, crematory or other place)  4 Donation /5 Other (Specify)  21. Signature of June 1 Service Leanse JONATHAN D. HIBNER. Name and Address of Facility PHILLIPS FUNERAL HOME.	own, State
Cemetery, crematory or other place)  1 Burial 2 Cremation 3 Removal from State  1 Donation 5 Other (Specify)  Carried by Communication Communi	
m && E & B   wat	•
23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock of hear failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Physician Immediate Cause (Final disease or condition resulting in death)  Medical Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of the c	1 day
Examiner Company atteroscionesis	years
Sequentially list conditions, b. Due to or as a considerace of cause. Enter Undertying Cause (Disease or injury Dealettes melletus)	0
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physician the buria dical E	
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Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Cause (Disease or injury that initiated events resulting in death) Last  Ca	ory Day Year
2 O o o o o o o o o o o o o o o o o o o	Day Toal
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the	ne cause of death?
Sign of a Colenocorcerona, lung 1 - Yes 2 No 3 - Probi	ably 4 Unknown
1 Yes 2 No 3 Probe  1 Yes 2 No 3 Probe  24a. Was an autory prior to con	psy findings available appletion of cause of
☐ Performed?   death!   1   Yes 2   No 1   Yes	
26. Place of Death (Check only one)	o
1 Pinpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Residence 6 Other (Specify	/)
27. Many of Death  1	
27. Mann of Death    27. Mann of Death   28a. Date of Injury   28b. Time of Injury   28c. Injury at Work?   1   28c. Describe how injury occurred   28d. Describe how injury o	l Route Number,
29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as sta	
288. Place of Injury - At home, farm, street, factory, office  281. Location (Street and Number or Rural determined)  282. Location (Street and Number or Rural determined)  283. Location (Street and Number or Rural determined)  284. Location (Street and Number or Rural determined)  285. Location (Street and Number or Rural determined)  286. Place of Injury - At home, farm, street, factory, office  287. Location (Street and Number or Rural determined)  288. Location (Street and Number or Rural determined)  289. Location (Street and Number or Rural determined)  290. Location (Street and Number or Rural determined)  291. Location (Street and Number or Rural determined)  292. Location (Street and Number or Rural determined)  293. Location (Street and Number or Rural determined)  294. Location (Street and Number or Rural determined)  295. Location (Street and Number or Rural determined)  296. Location (Street and Number or Rural determined)  297. Location (Street and Number or Rural determined)  298. Location (Street and Number or Rural determined)  299. Location (Street and Number or Rural determined)  290. Location (Street and Number or Rural determined)  290. Location (Street and Number or Rural determin	
(Check only one)    Check only one)   Check only one)	
Filliam & Green, In, 10, 1004164 gary 21	, 2004
30. Name and address of person who compreted cause of death (Item 23a) (Type, Print)  NILLIAM I HICKEN, M.D. ST, AGNES HOSPITAL BALTIMORE, MD 2	1/229
State 31. Date filed (Month, Day, Year) 32. Reciprar's Signature  Registrar  JUL 2, 4, 2006	

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day **Physician** Gregory July 21,2006 Callow 6:06p M Wavne /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 946A Sevarden Lane Crownsville Anne Arundel 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours Min 1**∑**M 2□ F 219-90-7500 Yrs. Director 42 6/25/1964 Maryland Usual Residence of Decedent the Maryland 10c, City, Town or Location 10a State 10b County 10d. Inside City Limits 28a-f show item 27 is marked other than "naturel", or Itema 23s or 28s-f shov other traumatic event, the Madical Examiner must be notified at MD Anne Arundel Crownsville 1 ☐ Yes 2 ☑ No Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 946A Sevarden Lane 21032 USA death \ Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: ģ Specify: White 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7; Dapartment of Heelth and Mental Hygiene Important: if item 27 is marked other than "na any injury or other traumatic event, the Medic one. (Specify only highest grade completed) Elementary/Secondary (0-12) Steamfitter's College (1-4or 5+) Steamfitter 12 Local 602 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Edwin Charles Callow Gloria May Piper 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Kristina Callow/Daughter 11408 Castle Lane Ellicott City, Md21042 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Chesapeake Crem. 7/24/06 Beltsville, Md 4 □ Donation 5 □ Other (Specify 21. Signature of Juneral Service I PHILIP OCRINALDI FUNERAL SERVICE, P.A. 9241 Columbia Blvd, Silver Spring, Md20910 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Liver Failure 3 mo./Medical Due to (or as a consequence of): Examiner Chronic Hepatitis C 23 yrs. Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No To the Hospital or Attending Physicien: within 24 hours efter death.

To the Funeral Director: After this certifica completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 ☐ Nursing Home 5 ☑ Residence 6 ☐ Other (Specify) Yes 2□ No 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title at certifier 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 28a) (Type, Print) 6,21 Ridgeley Avemue #201 Annapolis, Md Charles King MD DOALS! 31. Date filed (Month, Pay, Year) 2006 32. Registrar's Signature State

Registrar

State of Maryland / Department of Health and Mental Hygien [ ] 1 - State Registrar Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Dr. Raymond Allison Carpenter, Sr. PhD 2006 1.357 Julv /Medical 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner Carroll Westminster Carroll Hospital Center If Under 1 Year | If Under 24 Hrs. 8. Date of Birth Month, Day, Year, July 12, 1921 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1**√**M 2□F Months Days Hours Canada 85 425-09-3937A Yrs. Director Usual Residence of Decedent with the Maryland 10d Inside City Limits 10c. City, Town or Location 10a. State 10b County r than "natural", or Itema 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes XXNo Svkesville Directo Carroll Maryland 10f, Zip Code 10g. Citizen of What Country? 10e. Street and Number United States 21784 3994 Robin Hood Way death v 12. Was Decedent Ever in U.S. Armed Forces? 1 XXes 2 □ No If Yes, Give Year or Dates: WWII 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Illimportant: If Item 27 ie marked other than "natural", or iter any injury or other traumatic event, the Medical Examinam once. 1 Never Married 2XXMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: White þ 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Federal Government Physicist  $5\pm$ 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) unknown unknown 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sykesville, MD 21784 3994 Robin Hood Way Wife <u>Edna Carpenter</u> 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 14 Burial 2 Cremation 3 Removal from State July 25, 2006 Knoxville, TN Woodlawn Cemetery 4 □ Donation 5 □ Other (Specify) e of Funeral Service Lice so 21. Signatu Burrier-Queen Funeral Home & Crematory, Burrier-Queen Funeral Home & Crematory, PA 1212 W. Old Liberty Road Winfield, MD 21784 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Abdominal **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner been signed by the attending physiclen and should be detached for use as the burial-transit The taw requires that the death certificate be executed MIME that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month Day 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown 24a. Was an autopsy performed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No ate has b certificate arkinsonism 1□ Yes 2☑No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Dther: 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Tes 2 No ၉ 1 Impatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After thi 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 5 Pendina 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Sign tury and title Name and address of person who completed cause of death (Item 23a) (Type, Print) Malcalm dure, went munity HD 21157 aneus 32. Raistrar's Signature 31. Date filed (Month State

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Please Type or Print in Black Indelible Ink, Ensure All Copies Are Legible.
AMEND 1114#20b, perFH C859, 9/20/06, WS
State of Maryland / Department of Health and Mental Hygiene 2 1 1

1 - State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>2006 July 11, Year **Physician** Charles Α. DiGiulian 4:00 A M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Bethesda Health Care & Rehab Ctr Bethesda Montgomery 8. Date of Birth Sept 11, 1918 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign **Funeral** Months Days Hours XXM 2□F Washington DC 579 10 6998 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 7 is marked other then "naturel", or Itsms 23a or 28e-f show trsumetic svent, the Modical Examinar must be notified at tyTYes 2 ☐ No Director N/A Washington DC N/A 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20002 325 G. Street NE United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? XXYes 2 □ No WWII Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. e filed within 72 hours atter ( al Hygiene. I other then "naturel", or Iter Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☐ No by Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Career Military Department of Defense permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If itsm 27 is marked oth any injury or other traumatic event 2008. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Emma (UNKNOWN) Anthony DiGiulian ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 325 G. Street NE Washington, DC 20002 Robert R. DiGiulian (Nephew) 20a. Method of Disposition

1 Absurial 2 Compation 3 Removal from State
4 Donation 5 Other (Specify) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 10-5-2006 Arlington National Cemetery Arlington, Virginia 22. Name and Address of Facility Lee Funeral Home, Inc 6633 01d 21. Signature of Funeral Service Licensee \_mo 1461 Alexandria Ferry Road, Clinton, MD 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, mack, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Aspiration Pneumonia /Medical Due to (or as a consequence of): Examiner Myocardial Infarction Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physician and for use as the burial-transit Due to (or as a consequence of) Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes XX No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificate has autopsy performed? Yes 2XXNo 1 ☐ Yes 2 ☐ No 1 ☐ Yes or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 📉 💥 📉 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident hours after death 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a To the Funerel 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifle July 20, 2006 D 27660 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Alpana Goswami, M.D. 11119 Rockville Pike 6-100, Rockville, MD 20852

Registrar

State

31. Date filed (Month, Day, Year)
JUL 2 4 2006

Division of Vital Records, P.O. Box 68760

32. Registrar's Signature

			For State Registrar	State of Marylar		artment rtificate			ind M		giene Reg. No.	_ 0 0 0	23091
	Physici	an	Decedent's Name (First, Middle, Last)	Tag						2. Date of De Month July 21	Day	, Year	3. Time of Death 4:00 pm M
	/Medic Examin		George Dudick,  4a. Facility Name (If not institution, give st			4b. City, To	own, or	Location o		oury 21	-	County of De	
	LXdiiiii		7 Forest Road			Midd	le F	River			E	Baltimo	ore
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Months	Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da	th y, Year)	9. B	irthplace (State or Foreign Country)
	Director		Usual Residence of Decedent	84	Yrs.					4/23/1	922	Pe	ennsylvania
	/land		10a. State 10b. County	10c. Cit	ty, Town or Lo	cation							10d. Inside City Limits
	ath with the Marylan 23s or 28e-f ehow ust be notified at	tor	Maryland Baltimor	e Mio	ddle Ri	iver							1 ☐ Yes 2 🛣 No
	or 28	Director	10e. Street and Number			10f. Zip 0	Code				10g. Citi	zen of What (	Country?
	ath w 238		7 Forest Road			212						S. A.	
	item de	Funeral	11. Marital Status  1 Never Married 2 Married	2. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ▼No	.S. 13.	Was Decede f Yes, specif	nt of His y Cubar	spanic Orig n, Mexican	gin? (Spe , Puerto	ecify Yes or No Rican, etc.)	-	14. Hace - An Black, Wh	nerican Indian, nite, etc.
036	urs at	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No	Specify:				Specify: W	hite
215-0036	be lied within 72 hours after death with the Maryland Hygiene. All Hygiene. and other then "naturel", or iteme 23a or 28e-f ehow event, the Madical Examiner must be notified at	Completed	15. Decedent's Education (Specify only highest grade		16a. Deced	dent's Usual kind of work	Оссира	tion u <i>ring</i> most	of worki	na	16b. Ki	nd of Busines	s/Industry
2	hen "	mpl	Elementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT use	retired)				a.	1 - 3	
2	filed v Hygie other t	Co	11 17. Father's Name (First, Middle, Last)		Super	intend		18 Mothe	r's Name	(First, Middle,		el Inc	lustry
an	ag la ba	To Be	George Dudick, Sr	•					e K			<i>-</i>	
Maryland	d 2 should th and Men ?7 ie marke traumatic	-	19a. Informant's Name/Relationship (Typ		19b. Mailir	ng Address (	Street a			I Route Numbe	er, City o	r Town, State,	Zip Code)
	1 and 2 Health a em 27 i		Sharon Ann Rahe (D							rnie, M			
Baltimore,	Se Co		20a. Method of Disposition 1   ☐ Burial 2 ☐ Cremation 3 ☐ Re	mioval iloni State	Place of Dispo cemetery, crem			1		7/25	20c. Lo	ocation - City o	or Town, State
	permit. Page Department of Important: If any Injury of once.		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licenser		cred He					7625 2606		ndalk,	Maryland
Ba	Depa Impo		21. Signature of America Service Licenses	11.00 500	Bi 1	ruzdzi 407 ol	nski d Fa	i Fun	eral	Home E	A Teses	z Mars	land 21221
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused the deal								r Plany	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Conge	stive	- He	aR	T Fa	ilus	e			Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consec		1		7					7 9 24 3
		-	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseq	1dvy	AVTE	ry	DIS	ease				Zoyears
	d d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events										
Ö,	ate be executed hysicien and the burial-transit	Exa	resulting in death) Last	Due to (or as a consec	juence of):								
8760,	death certificate be executed e attending physicien and d for use as the burial-transit	dlcal	d.										
9 X	eath certific attending p	/Me	IF FEMALE: 23b. Was decedent pregnant	ic. If yes, outcome of pregna	ancy							23d. Date of d	elivery
		Physician/Med	in the past 12 months? 1 Yes 2X No	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown		Ectopic pred Other (spec						Month	Day Year
o.	at the de d by the a stached i	Phys	9 Unknown										
S,	The law requires that the ate hes been signed by the page 2 should be detache	þ	Part II. Other significant conditions cont	nbuting to death but not res	sulting in the u	nderlying cau	use give	n in Part I.			obacco u Yes 2 [		to the cause of death?
Records,	w require been signal	etec								24a. Was			
Re	nysician: The law nis certificate hes b I director, page 2 s	Completed						-		autop	rmed?	prior to	autopsy findings available completion of cause of
ta		Be Co	25. Was case referred to medical					26. Place	of Death	1 Yes	2 <mark>X</mark> No ле)	1	s 2 No
>	Physician: r this certific ral director,	70 E	examiner? 1 ☐ Yes 2 ŽNo	ospital: 1 Inpatient 2 I	ER/Outpatien	it 3 DOA	Othe	r: 4 □ Nui	rsing Hor	ne 5∭ Resid	dence (	5 □Other (Sp	ecify)
פ	Se Table		27. Manner of Death 1   Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		c. Injury Work			28d. Describe f	now injur	y occurred	
Division of Vital	Attending it death.	flcat	2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h	ome, farm, str	M eet factory		′es 2 □ N		28f. Location (S	Street an	d Number or I	Rural Route Number,
2	alor A s after al Dire	Certification;	4 Homicide	building, etc. (Special	(y)	,,,				City or Tov			
	To the Hospital or Attendit within 24 hours after death. To the Funeral Director: A completely filled in by the fu	edical (	29a. Certifier 1 X Certifying Physi (Check only 2 Medical Examini one)	cian: To the best of my knoer: On the basis of examina and manner stated.	owledge, death	n occurred at vestigation, i	t the time	e, date and inion, deat	d place, a	and due to the ad at the time,	cause(s) date and	and manner a	as stated. ue to the cause(s)
	To the within 2 To the comple	Me	29b. Signature and title of certifier	171				number					nth, Day, Year)
			Keed Day	1D Killy	MD		D4	756	,0		No	24	2006
	10		30. Name and address of person who con	71 1000 11	п 23а) (Туре,	Print)	- 11	R. 1		1 Roll	110	, mi	2006
	Sta	te	31. Date filed (Month, Day, Year)  JUL 2 4 200	11ey MD 9	124 ( ature	ample	1991	Doule	Var	1 10171	MOYE	, //(1)	21236
	Registr		JUL 2 4 200	6 Delus	b. Go	ale							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] [ 1 - For State Registrar Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death Month 07 Day Physician 16 2006 12:00 PM Jennette Lee Jones Epps /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number, Examiner Washington Adventist Hospital Montgomery Takoma Park If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 12/13/1931 5. Social Security Number 7. Age (In vrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 ☐ F Yrs. 74 239-48-2704 Virginia Director Usual Residence of Decedent the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location or items 23a or 28a-1 show permit. Peges 1 and 2 should be filled within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or items 23a or 28s-1 shown my injury or other traumatic event, the Mudical Examination must be cattlied. ty⊡Yes 2 No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20018 IISA 3298 Fort Lincoln Drive, N.E. #609 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. I □ Yes 2 M No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 21 No 2 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Security Guard Private Industry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Unknown Arlethia Jones ٥ 19a. Informant's Name/Relationship (Type, Print) ster in 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8717 East Grove; Upper Marlboro, MD 20774 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ₺ Burial 2 Cremation 3 Removal from State Ft. Lincoln Cemetery 07/22/2006 Brentwood, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 3831 Georgia Avenue N.W. Williams Kulph Latney's Funeral Home Washington, DC 20011 Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final **Physician** disease or condition resulting in death) DSI /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate causs. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed detached for use as the burial-transit and Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Year Month Day 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ð 1 ☐ Yes 2 ₹ No 3 ☐ Probably 4 ☐ Unknown After this certificate hes been si funeral director, page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? Leto. 1 ☐ Yes 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No Certification: To 1. Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Injury 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital 29a. Certifier to Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medicai 2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) DUSCCO

Registrar

State

31. Date filed (Month, Day, Year) 32.

JUL 2 4 2006

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300,

30. Name and address of person who completed cause of death (Item 3a) (Type, Print)

CALL



ALIT

CM. 124 BOLIO

RONALD EATON 06-05113 UNK UNK

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		rtificate of	Death		2 U	U6 2309
Physicia Medical Examir	4.0	1. Decedent's Name (First, Middle,Last)  RONALD EATO	N			2. Date of Deat Month	Day Year	3 Time of Death 1850 hrs
noundar Examin		4a. Facility Name (if not institution, give street a		4	b. City, Town, or Location of	July 16, 20 of Death	4c. County of D	
Segue of		1722 McCullah Street			Baltimore			
Funeral Director		5 Social Security Number 6. Sex 214-38-5432 1X M 2	7. Age (În yrs. la		If Under 1 Year If Under 1 Months Days Hours	Min	i Fo	Birthplace (State or preign
	-	214-38-5432 1X M 2 Usual Residence of Decedent	F 63	Yrs.		09/26/	1942	Country) MD
vany	ľ	10a State 10b. County	10c. City,	Town or Location	on	-		10d. Inside City Limits
Maryland 28a-f show any d at once.	ģ	MD	BAL	TIMORE				1 X Yes 2 No
or fie	Director	10e. Street and Number 1722 MCCULLOH STREET			10f. Zip Code <b>21217</b>	10	Og Citizen of What ( USA	Country?
with the ns 23a be noti			s Decedent Ever in U.	S. 13. Was	Decedent of Hispanic Orig	gin? ( Specify Yes or No-	14 Race - Ar	merican Indian, Black,
r death or iter must	Funeral	1 X	ned Forces? Yes 2 No		es, specify Cuban, Mexican,	, Puerto Rican, etc.)	White, et	
irs afte	اھ	3 Widowed 4 Divorced If Yes, G or Dates  15. Decedent's Education (Specify only higher	ve Year 1960-64		Yes 2 No specify:	kind of work done	Specify: BL	
72 hou	Completed		ege (1-4 or 5+)		est of working life. DO NOT			ass, in dassity
5-0036 Tiled within 72 Hygiene. d other than '	d L	47.5 11.4 11.1 15.1	_ 4	CLE	RICAL		BETH S	TEEL
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	17. Father's Name (First, Middle, Last)  HASSEL EATON			18 Mother	's Name (First, Middle, M	,	
21214 hould be fill and Mental F is marked rife event, i		19a. Informant's Name/Relationship (Type, Prin	t )	19b. Mailing	Address (Street and Num			tate, Zip Code)
e, MD I and 2 sho Health and item 27 is	I	RONALD EATON, JR./SO		555 M	ASSACHUSETTS			
- s - = e	ŀ	1 XX Burial 2 X Cremation 3 Rem	oval from State	cremate CIR	tion (Name of cemetery, place)	Date 07/25/2006	20c. BALTIM	
Baltimo permit. Page Department o Important: injury or oth	H	4 Donation 5 Other Specify: 21. Signature of Funeral Service Licensee	4 1		ame and Address of Facility			
Depr. Depr. Inju	ŀ	James gi	Morlin		01 LAURENS S	JAMES A. M		ONS F.H, INC
Physician /Medical		23a. Party Enter the disease, or complications failure. List only one cause on each line.	that caused the death.	. Do not enter th	e mode of dying, such as ca	ardiac or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
Examiner	1		erosclerotic or as a consequence of		cular disease			Death
Sec. of		Sequentially list conditions, b.	n as a consequence of					
	Examiner	if any, leading to immediate Due to (cause. Enter Underlying Cause	or as a consequence of	f):				
d sit	Xal		or as a consequence of	f):				
execute		TX UNPENDED A AMEN	DED 20a-C DG	er fh o	357.7-24 <del>.</del> 06 x	7t		<del> </del>
760, icate be executed physician and the burial - transit	Medical	IF FEMALE: 23c. I	DED 20a-c per	27 perME	g859,9/17/06 TT		23d Date of deli	very
OX 687 sath certific attending p		past 12 months?	Live birth Pregnant at time of de	oth	al death 3 Ectopic	pregnancy	Month	Day Year
Box 68 e death certifi the attending ed for use as	Physician	1 Nos 2 No 0 No 11-line	Unknown	oath 5 Oth	er (Specify)			
hat hat	by Pt	Part II. Other significant conditions contribu	iting to death but not re	esulting in the u	nderlying cause given in Pa			e to the cause of death?
ords, P w requires t is been sign should be c	ted t					1Yes 		Probably 4  Unknown
COTC law reshas be	Completed					autops	sy prior	a autopsy findings available to completion of cause of n?
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been siled in by the funeral director, page 2 should be		25. Was case referred to medical			26.Place of Death	1 Ves 2	No 1	Yes 2 No
Vital   ysician: his certif director,	To Be	examiner?  1 ✓ Yes 2 No	Inpatient 2	ER/Outpatient	Othor	-	Residence 6 🗸 0	ther: Scene
Division of 'pital or Attending Phous after death.  Icral Director: After Iffled in by the funeral		27. Manner of Death	Date of Injury (Month, Day,Year)	28b. Time of Ir			ow injury occurred	
Sior Attend death. death.	läi Jäi	2 Accident Investigation	Diago of Injury At he	6	1 Yes 2			B IB WWW.
Divis	Certification:	Suicide Could not be	ecify)	ome, iarm, stree	t, factory, office building, etc	or Town, St		Rural Route Number, City
Hospi 24 hou Funer		29a. Certifier (Check only 1 Certifying Physician: To the						
To the How within 24 h To the Fur completely	Medical		basis of examination at nner stated.	nd/or investigati		curred at the time, date a	and place, and due to	o the cause(s)
J. J.	Σ	29b. Signature and title of certifier	101		29c. License number O.C.M.E.		29d. Date signed ( July 17, 2006	Month, Day, Year)
"V"		30. Name and address of person who complete	d cause of death (Item	23a)	3.0.0.		Saly 17, 2000	
V** \			ledical Examiner		n Street, Baltimore, N	MD 21201		P
	ate	31. Date filed (Month, Day, Year) 2 2006	32. Registrar's Signatu	le A				
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0.0145.0000				CITIOHINAL	-			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 07 0025 M 21 06 FREDERICKS KENNETH ALLEN /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Fecility Name (If not institution, give street and number) Examiner WICOMICO PENINSULA REGIONAL MEDICAL CENTER SALISBURY | SALLDBURL | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | MAY 16, 19 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1XX 2 F PENNSYLVANIA Director 206-32-2953 Usual Residence of Decedent Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County or then "neturel", or iteme 23s or 28s-f show the Madical Examinar must be notified at SALISBURY 1 Yes 2 No WICOMICO MARYLAND Directo the 10g. Citizen of What Country? 10e Street and Number 10f. Zin Code UNITED STATES 21804 221 SANDY BOTTOM COURT 12. Was Decedent Ever in U.S. Armed Forces? 1960-14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1XX es 2 □ No If Yes, Give Year or Dates: 1 Never Married 200 Married WHITE 1964 Maryland 21215-0036 1 ☐ Yes 2XXXVo À 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) GODDARD SPACE CENTER 12 COMPUTER PROGRAMMER 17. Father's Name (First, Middle, Last) 18 Mother's Name (First Middle Maiden Sumame) Be MARGARET BYNON FREDERICK G. FREDERICKS 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 221 SANDY BOTTOM COURT, SALISBURY, MD ROSELLA FREDERICKS / WIFE Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) JULY 26, 20c. Location - City or Town, State 20a Method of Disposition Pages 1 Burial 2 Cremation 3 Removal from State CRWONSVILLE MD VET. CEM. 2006 CROWNSVILLE, MD 4 Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee KIRKLEY-RUDDICK FUNERAL HOME P.A. 23a. Part I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one parse on each line. 421 CRAIN HWY, S.E. GLEN BURNIE, MD 21061 Approximate Interval Between Onset and Death Immediate Cause (Final INTHACENEBRAL HEMOPHAGE **Physician** DAY resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Hospitel or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medica ettending for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy Day in the past 12 months? 4□Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 I Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Manpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 X Yes 2 □ No 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 24 hours e Funerei I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) To the P within 2 29c. License number 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 7/22/06 Robert all D29168 M.D. 0 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) ALLEN M.D. 1346 DIVISION ST., SALISBURY MD 21804 ROBERT 31. Date filed (Month, Day, Year) 24 2006 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene ? Certificate of Death 2. Date of Death Month 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** JULY 2006 11:27 A.M MARGARET L. GORSUCH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner TOWSON BALTIMORE GILCHRIST CENTER If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) 12/1/1917 Birthplace (State or Foreign Country) **Funeral** 1 M 2 TF Yrs. 88 Director MARÝLAND 213-38-6030 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits worde. r than "naturel", or items 23a or 28a-f ehov the Medical Examinar must be notified at 1 Yes 2 No Director BALTIMORE GLEN ARM 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 11630 GLEN ARM ROAD 21057 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: þ Specify 3 XWidowed 4 ☐ Divorced WHITE Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry BALTIMORE COUNTY al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) BOARD OF EDUCATION YEARS SCHOOL TEACHER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) marked JOHN SIEBERT ELIZABETH L. KEAGLE 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) partment of Heelth as contant: if item 27 is njury or other treu -EDWARD C. GORSUCH, JR./SON 3713 PARKHURST WAY BALTIMORE, MD altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages Department of h Important: If its any injury or of ance. 1 Burial , 2 Cremation 3 Removal from State DULANEY VALLEY MEM. 4 □ Donation 5 □ Other (Specify) 7/26/2006 COCKEYSVILLE, MD GARDENS Name and Address of Facility THE JOHNSON FUNERAL HOME, P.A. 21, Sign tur of Funeral Server Licensee permit. 8521 LOCH RAVEN BLVD. TOWSON, MD 23a/Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) 57 ndvome **Physician** weeks /Medical Examiner 10 10 10 10 10 ce Sequentially list conditions, if any, leading to immediate cause End of Dorning Cause (Disease or injury that intilated events resulting in death) Last Due to (or as a consequence of) Examine physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760 Physician/Medical igned by the attending be detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. ۾ 1 Yes 2 No 3 ☐ Probably 4 ☐ Unknown certificete has been si rector, page 2 should I Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 Yes 2 No 1 Yes 2 No Division of Vital Hospital or Attending Physician: 25. Was case referred to medical funeral director 26. Place of Death |Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending death. 1 Yes 2 No 2 Accident investigation ofter death Director: A 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours of To the Funerel D completely filled in 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier (Check only 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. ş 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 025205 30. Name and address of person who completed cause of agath (Item 23a) (Type, Print) N. Charles St. Balto. Md 21208 6701 6 Binc 32. Registrar's Signature 31. Date filed (Month, Dey, Year)

Registrar

24 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) <sup>Day</sup> 2006 Year Physician July 19, 8:30 PM Erie Margaret Gingher /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2605 Chapel Lake Drive #103 Gambrills Anne Arundel 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 F 82 Yrs. Ohio Director 201-12-3372 Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City. Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1 Tyes 2 No Directo Maryland | Anne Arundel Gambrills 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a or 2605 Chapel Lake Drive #103 21054 United States death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 Ie marked other than "natural; or Item any injury or other traumatic event. The Medical Examina Black, White, etc. I Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify: þ 3 XWidowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry College (1-4or 5+) 2yr Elementary/Secondary (0-12) Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 Beard Eva Darling James Brisbin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Cyndia Jane Busler/daughter 2605 Chapel Lake Drive #103 Gambrills, MD 21054 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 【XCremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) West Arundel Crematory 7/24/2006 Odenton, Maryland 21. Signal re of Funeral Service Licen 22. Name and Address of Facility Donaldson Funeral Home & Crematory, P.A. 1411 Annapolis Road Odenton, Maryland 21113 with Homer Approximate
Interval Between
Onset and Death
5 years 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Peripheral Vascular Disease **Physician** years /Medical Due to (or as a consequence of) Examiner 20 years Diabetes, Type Saturations at conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician; The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, physicien Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 🔯 No Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1XYes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2X No 1 ☐ Yes 2 No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) Be examiner' Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home 5 XResidence 6 Other (Specify) Certification: To 1 ☐ Yes 2 💢 No 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury t XNatural 2 ☐ Accident 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A investigation the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) in by t Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Filled Hospital 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Unack only one) 를 29b. Signature and title of certifier 29c. License number 29d. Date, signed (Month, Day, Year) 30. Nam, and address of person who completed cause of death (from 23a) (Type, Print) 2401 Brandermill Blvd. Suite 220 Gambrills, Maryland 21054 Ruth K. Gallatin, M.D. 31. Date filed (Month, Day, Year) 32. Pegistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

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2006

			1 - For State Registrar	State of Maryland / Dep Ce	partment of Headertificate of De	alth and M eath		ene) () (	23097
75	Dhuaisi	*5	1. Decedent's Name (First, Middle, Last)				2. Date of Death Month	Day Yea	3. Time of Death
	Physici /Medic		Karuther		Hemby		July	18 200	
1	Examin	er	4a. Facility Name (If not institution, give s		4b. City, Town, or Lo			4c. County of De Baltir	
	3K 		Future Care Nurs 5. Social Security Number 6. Sex	7. Age (In yrs. last birthda	Randal I	Under 24 Hrs.	8. Date of Birth	9. 8	irthplace (State or Foreign
	Funeral Director			M 27 F 78 Yrs.		Hours Min.	(Month, Day,	Year)	Country) NC
	ים מי		Usual Residence of Decedent				TT T3		
	arylar ahow	_	10a. State 10b. County	10c. City, Town or					10d. Inside City Limits 1   Yes 2   No
	8a-f	Director	MD NA	Baltim				- 0%	
	with the	5	10e. Street and Number		10f. Zip Code 212	16	10	g. Citizen of What	
	eath	Funeral	3043 Brighton St		. Was Decedent of Hispa	anic Origin? (Spe	ecrify Yes or No-		nencan Indian,
(0	r Iten	Fun	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2X☐ No	If Yes, specify Cuban, I	Mexican, Puerto	Rican, etc.)	Black, Wi	
္တိ	ral', o	by	3 XWidowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 21 No S	Specify:		Specify:	Black
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene.  d other than "natural", or items 23e or 28s-f show event, the Madical Exactions than notified at	Completed	15. Decedent's Educ (Specify only highest grade	completed) (Gir	edent's Usual Occupation in the kind of work done duri		ng 1	6b. Kind of Busines	ss/Industry
121	within in e. Ihan	ldm	Elementary/Secondary (0-12)	College (1-4or 5+)	DO NOT use retired)		III	no Dat	e Laundry
Ω Φ	Hygie Hygie thar i		12th grade 17. Father's Name (First, Middle, Last)	na	Clerk 18	3. Mother's Name	Ψ <u>Ε</u> (First, Middle, M		e naunary
an	Mental Mental arked o	To Be	James Knox		1	Lucy Da	aniel		
Maryland	2 should and Men Is marke aumatic	-	19a. Informant's Name/Relationship (Typ	e, Print) 19b. Ma	iling Address (Street and			City or Town, State	, Zip Code)
	1 and 2 Health a lam 27 la		William Hemby J	c-Son 321	9 Sequoia	Ave, E	Baltimo	re, Md	21215
ore,	iges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hyglene.  If it itam 27 is marked other than "natural", or iteme 23s or 28s-f show or other traumatic event, If a Maribal Examilier mast be notified at		20a. Method of Disposition  1 X Burial 2 □ Cremation 3 □ Re	20b. Place of Dis	position (Name of ematory or other place)	C	Date 2	Oc. Location - City	or Town, State
<u>Ĕ</u>	Pag ment ant: h		4 Donation 5 Other (Specify)	Garris	on Forest	Vet.7	/24/06	Owings I	Mills, Md
Baltimore,	permit. Pages 1 and Department of Heat Important: If Item 2 any injury or other 2005s.		21. Signature of Funeral Service License	1. Neke 4	22. Name and Address of arch F/H 1 300 Wabasi	h Ave,	Baltim	ore, Md	21215
1			23a. Parti. Enter the disease, or complic shock, or hear failure. List only on	ations that caused the death. Do not each line.	nter the mode of dying, s	such as cardiac o	or respiratory arres	st,	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	Meterotot			nda		Offset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):		1			
		J.	Sequentially list conditions, b.	Due to (or as a consequence of):	Meta o	Bom.			
	nsit /#/	nln	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		ote J	aunc	he.		
Ć,	execu in and iaf-tra	Examiner	that initiated events c. resulting in death) Last	Due to (or as a consequence of):					
8760,	death certificate be executed attending physician and affor use as the burial-transit	dical	<b>U</b> <sub>d</sub>						
9	rtifica ng ph s as th	Med	IF FEMALE:						E
Вох	that the death certification of the attending of detached for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?		□Ectopic pregnancy			23d. Date of o	lelivery Day Year
0	the a	sic	1 ☐ Yes 2 MNo 9 ☐ Unknown	4☐Pregnant at time of death 5 9☐Unknown	i Other (specify)				,
Δ.	requires that the been signed by th hould be detache	Ph	Part II. Other significent conditions con	ributing to death but not resulting in the	underlying cause given i	in Part I.	23e. Did toba	acco use contribute	to the cause of death?
Vital Records,	98	d by	Sentize	mi2			1 🗌 Yes	2 No 3	Probably 4 Unknown
COL	w require been si should b	Completed	ACATO	Renal tailu	~ P		24a. Was an	24b. Were	autopsy findings available
Re	The law ate has t page 2 s	dwc	7,000	-1= Mall	L_		autopsy	ed? prior t death	o completion of cause of
tal		Φ	25. Was case referred to medical	the Much	). 26	6. Place of Death	1 Tes 21	-	95 223110
	Q 50	To B	examiner? 1 ☐ Yes 2 📉 No	ospital: 1  Inpatient 2 ER/Outpat	ent 3 DOA Other:	4 Nursing Ho	me 5 Resider	nce 6 Other (Sp	pecify)
0 0	ng Ph fter th meral	no:	27. Manner of Death 1 Matural 5 □ Pending	28a. Date of Injury (Month, Day Year) 28b. Time			28d. Describe how	v injury occurred	
Sio	Attending r death. ector: After by the fune	catl	2 Accident investigation 3 Suicide 6 Could not be			s 2 No			
Division of	or Ati	Certification:	4 Homicide determined	28e. Place of Injury - At home, farm, building, etc. (Specify)	street, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
	Hospital 14 hours a Funaral (		29a. Certifier 1 Certifying Phys	icien: To the best of my knowledge, de	ath occurred at the time	date and place	and due to the car	uso(s) and manner	as stated
	na Hospital or Attendi n 24 hours after death. ne Funaral Director: A sletely filled in by the fu	edical	(Check only 2 Medical Exemin	er: On the basis of examination and/or and manner stated.	investigation, in my opini	ion, death occurr	ed at the time, dat	te and place, and d	ue to the cause(s)
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: Atter th completely filled in by the funeral	Me	29b. Signature and title of certifier		29c. License n	umber	29	d. Date signed (Mo	nth, Dey, Year)
				me	0000	01430	3   1	07/20	100
	i		30. Name and address of person who con	nplete ause of death (Item 23a) (Typ	e, Print)				- V
	-\			cmisi m. 9 260	LIBERTY	HEIGHT	5 MR	BMITIM	oce ms 21215
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Signature	este				

		4	For Stata Registrar		State		and / Depa		t of H	lealth a	and M	Mental Hyg		_	6	230	198
			1. Decedent's Nam	e (First, Middle,	Last)							2. Date of Dea	ith Day		'ear	3. Time of I	Death
	Physicia /Medic		Janet Joa	an Hodges								July 22,				12:30P	М
	Examine		4a. Facility Name (I	If not institution,	give street and n	umber)		4b. City,	Town, or	Location	of Death		4c.	County of	Oeath		
			7503 Pills						en Bu		2111			ne Ar			
	Funeral		5, Social Security N	lumber (	5. Sex 1 ☐ M 22 K☐ F		rs. last birthday) Yrs.	Months	1 Year Days	If Under Hours	Min.	8. Date of Birtl (Month, Day March 26,	y, Year)	. 9	). Birthp Coun	lace (State or try)	Foreign
	Director	-	220-30-747 Usual Residence of	78 f Decedent		7.1	115.					march 26,	1935	)		PA	
	land wo	-	10a. State	10b. County		10c.	City, Town or Lo	ocation							10	0d. Inside Cit	y Limits
	Mary -f sh	ţo	MD	Anne Arui	nde1	G	len Burni	e								1 ☐ Yes	XX No
	r 288	Director	10e. Street and Nu					10f. Zip	Code				10g. Citiz	zen of Wh	at Coun	try?	
	h witl		7503 Pills	sburv Plac	ce			2	1060					USA			
	deal sms	ner	11. Marital Status			cedent Ever in	1 U.S. 13.	Was Dece	dent of Hi	ispanic Ori	igin? (Sp	pecify Yes or No- Rican, etc.)	1	4. Race -	Americ White, e		
9	or It	Fu		ried 🔏 Marne	d 1 ☐ Yes	2FTNo		1 ☐ Yes				7 110411, 010.7		Specify:			
S	ural',	P	3 Widowed	and the second	Year or	Dates:									Whit		
<u> </u>	"nat	Completed by Funeral	(Ѕрес	15. Decedent's cify only highest	grade completed	1)	16a. Dece	dent's Usu kind of wo DO NOT u	al Occupa nk done d	ation during mos	st of worl	king	16b. Kir	nd of Busin	ness/Inc	lustry	
72	within ene. then	m d	Elementary/Seco	ondary (0-12)	College	(1-4or 5+)	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Clerk	30 1011100	,				MVA			
20	filed Hygi other ent, I	ပိ	17. Father's Name	(First, Middle, L	ast)					18. Mothe	er's Nam	ne (First, Middle,	Maiden .	Sumame)			
Baltimore, Maryland 21215-0036	permit Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, Ite Modical Examinar must be notified at once.	To Be	Charles R	amsey						0pa	al Fiz	×x					
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Σ	and 2 alth a 27 I er tra		John Hodge	es Hi	usband		7503	Pill5b	ury P	lace,	G1en	Burnie, M	D 21	060			
ore	of He of He fiten		20a. Method of Dis		3 Removal from	n State	p. Place of Dispo cemetery, cre	matory or c	ther plac	e)		Date	20c. Lo	cation - Ci	ty or To	wn, State	
Ĕ	Pag ment ant: I			5 Other (Spe		14	leadowridg 	je Ceme	tery	J	July 2	26, 2006	Elkri	dge, l	MD		
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	/Medical Examiner		resulting in death)	1	Due to	o (or as a cons	sequence of.										
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Division of Vital Records, P.O. Box 68	gned be de	by	Part II, Other signi	ficant condition	s contributing to	death but not i	resulting in the u	inderlying o	ause give	en in Part I		23e. Did to	_			e cause of de	
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/ita	certific ector,	Be	25. Was case reference examiner?	rred to medical	Hospital:				01		e of Deal	th (Check only or	10)				
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n C	Jing I	lo	1 Natural	5 Pending investiga		e of Injury onth, Day Year,	) Injury	M	8c. Injury Work	rat ⟨? Yes 2□	No	200. Describe fi	ow injury	occurred			
isio	death death ctor: y the	ficat	2 Accident 3 Suicide	6 Could no	ot be	ce of Injury - A	t home, farm, st			103 20	110	28f. Location (S	treet and	l Number	or Rural	Route Numb	er.
<u>S</u>	after Dire J in b	Certification:	4  Homicide	determi	buil	ding, etc. (Spe	ecify)		,			City or Tow	n, State)				
	spita tours neral		29a. Certifier	Certifying	Physician: To the	he best of my l	knowledge, deat	h occurred	at the tim	ie, date an	nd place,	and due to the c	ause(s)	and mann	er as sta	ated.	
	10 - 10 10 - 10 10 - 10 10 - 10	edicai	(Check only one)	2 ☐ Medical E	xaminer: On the and ma	basis of exam inner stated.	ination and/or in	vestigation	, in my op	oinion, dea	ith occur	red at the time, d	late and	place, and	due to	the cause(s)	
	To the Hospital or Atlanding Physiclan: The law requires that the death certifica within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phycomple ely filled in by the funeral director, page 2 should be detached for use as the comple ely filled in by the funeral director, page 2.	M	29b. Signature and	title of certifier		, 1		290	. License	nedmber		. 2	9d. Date	signed (/	Month, L	Day, Year)	
				112	014	1/1			V.	ンノイ	3		14	1/2 2	-4	200	6
_	in		30 Name and add	ress of person w	no completed ca	use of death (I	tem 23a) (Type,	Print)		_		( ) (		/_	1	. / 1	
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 4:40 PM 2006 Daniel Lee Isaac James /Medical or Location of Death 4c. County of Death Examiner MONE If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Months Hours 1X M 2 ☐ F 247-48-6337 Director 02 Usual Residence of Deceden 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow If Health and Mental Hygiene.
If them 27 is marked other than "natural", or iteme 23s or 28s-1 show other treumstic event, the Mudical Examiner must be nutilised at 1 Yes 2 □ No Directo NA Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21229 29 North Monastery Ave U.S.A. Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married AMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: À Specify: Black 3 Widowed 4 Divorced Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 10th grade Hospital Laundry 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fit timent of Health and Mental H tant: If Item 27 is marked off jury or other treumatic even Lumisha Isaac Lionel Hartwell 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mary Isaac-Wife 29 North Monastery Ave, Balto, Md 21229 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: if eny injury or once. 4 □ Donation 5 □ Other (Specify) 7/26/06 Arbutus, Md Arbutus Memorial 21. Signatury of Fu 22. Name and Address of Facility
March F/H WEst 4300 Wabash Ave, Baltimore, Md 21215 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) PNEUMONIA **Physician** UNKHOWN /Medical Due to (or as a consequence of): Examiner CEMEBROVASCULAR DISEASE HOUTE Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examiner The law requires that the death certificate be executed the ettending physicien and that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760. Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death

4 Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant 3 Dectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 ☐ No Division of Vital Records, P.O. 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No autopsy performe this certificate 1 Yes 2 No filled in by the funeral director. 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗹 No 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident Diractor 6 ☐ Could not be 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Hospital or within 24 hours e To the Funeral L 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical completely and manner stated. 29c. License number PIS620 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier JULY 20, 2006 ppl payon who complaind paus of death (Item 23a) (Type, Print) Name an }~ 900 CATON AVE BALTIMOLE MARYLAND Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene

			State of Maryland	Certificate of			No 2006	23100
	Physic /Medi		1. Decedent's Name (First, Middle, Last)  THOMAS & SONE	s, Se.	2	2. Date of Death Month	Day Year 20	3. Time of Death
	Exami		4a. Facility Name (If not institution, give street and number) Mariner Health Care Center		4b. City, Town, or Loca Laurel	ation of Death	4c. County of Death Prince Ge	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last 470 05 3583 XX M 2 F 88	t birthday) Yrs.  If Under 1 Year Months Days		3. Date of Birth (Month, Day, Ye Aug 16,	9. Birth Cou 1917 Pa.	place (State or Foreign intry)
	Maryland e-f show	ctor		own or Location Beltsville				10d. Inside City Limits 1 ☐ Yes 2 ☐ No
	th with the 23a or 28 ust be not	ral Director	10e. Street and Number 4616 Blackwood Road	10f. Zip Code	.0705	10g.	Citizen of What Cou United	
020	nit. Pages 1 and 2 should be filled within 72 hours after death with the Maryland artment of Health and Mental Hygiene. ortant: If item 27 is marked other then "neturel", or items 23a or 28e-f show injury or other treumstic event, If a Medical Examinan must be notified at injury or other treumstic event, If a Medical Examinan must be notified at 8.	by Funeral	11. Marital Status  1 □ Never Married	13. Was Decedent of H If Yes, specify Cube  1 ☐ Yes 2 ☐ No	lispanic Origin? (Speci an, Mexican, Puerto Ri Specify:	fy Yes or No- can, etc.)	14. Race - Ameri Black, White, Specify: WI1	
Baltimore, Maryland 21215-0020	within 72 ho ene. then "netur re Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	6a. Decedent's Usual Occup (Give kind of work done of life. DO NOT use retired Supervisor	ation during most of working t)	16b	. Kind of Business/Ir	
yland 2	and 2 should be filed within eaith and Mental Hygiene. n 27 is marked other then 'n ner treumatic event, the Med	To Be Co	17. Father's Name (First, Middle, Last) Fred Jones	Dapervisor	18. Mother's Name (	First, Middle, Maid n Dwyer		оере.
, Mar	1 and 2 sho Health and I em 27 is ma other treums		Irene Boteler Jones (Wife)	19b. Mailing Address <i>(Street)</i> 4616 Blackwoo	d Road, Be	ltsville		
imore	pemit. Pages 1 an Department of Heal Important: If item 2 eny injury or other once.		Application 3 Linemoval noni state	e of Disposition <i>(Name of</i> etery, crematory or other place land Veterans	Cemetery	C		, Maryland
Ball	permit. Depart Import eny inj		21. Signature of Funeral vice Ligensee  23a. Part1. Enter the disease, or complications that caused the death. D shock, or heart failure. List only one cause on each line.	Alexandria		d, Clint		0735
	Physician /Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Muumo Mu	•				Approximate Interval Between Onset and Death
x 68760,	law requires that the death certificate be executed as been signed by the attending physician and a 2 should be deteched for use as the buriel-transit	/Medical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Late design of the trigitated experts.	a consequence of):				
, P.O. Box	that the death ce ned by the attendi	y Physician/	Part II. Other significant conditions contributing to death but not resulting	g in the underlying cause give	en in Part I.	23b. Did tobace	./	o the cause of death?
Vital Records,	e law requires t has been sign ge 2 should be	Completed by				24a. Was an au performed?	av co	ere autopsy findings ailable prior to mpletion of cause death?
Vital F	page 1	Be	25. Was case referred to medical examiner?	- Other	26. Place of Death (		2 1 No 1 [	Yes 2□ No
Division of	Attending Phys or death. ector: After this by the funeral di	Certification: To	1	o. Time of 28c. Injury Work	Yes 2 □ No	d. Describe how in	and Number or Rura	
	Hospita 24 hours Funerel etely fille	edical Cer	29a. Certifier (Check only one)  Check only one)  Certifying Physician: To the best of my knowled; 2 Medical Examiner: On the basis of exemination and manner stated.	lge, death occurred at the tim and/or investigation, in my or	e, date and place, and pinion, death occurred	due to the cause	(s) and manner as s	tated. the cause(s)
)	To the comple	Me	29b. Signature and title of certifier Kukseti	29c. License			Date signed (Month,	Day, Year)
	12/		30. Name and address of person who completed cause of death (Item 23a /420 / Laurel Certa Drive 22  31. Date filed (Month, Day, Year)  32. Segistrar's Signature	-	52075 I , mo	-2070	7	
	Sta	re.		13 . 29 .				

			For State Registrar	State of Ma		artment of rtificate of		nd Me		ene)	006	231	01
	Dhusisi		1. Decedent's Name (First, Middle, Las	st)				2.	Date of Death Month	Day	Year	3. Time of [	Death
_	Physici /Medic		LAWRENCE	ODEN	KEEN			Jl	ULY	20, 2	2006	12:45	a <sup>M</sup>
	Examin		4a. Facility Name (If not institution, give LAUREL REGIONAL HOSPIT	•		4b. City, Town, LAUREL	, or Location of	f Death			ounty of Death	RGES COUN	1TY
	Funeral Director		210 32 3010	ex 7. Age ☐ M 2☐ F	(In yrs. last birthday, 70 Yrs.	Months Day		Min.	Date of Birth (Month, Day, 1 EB. 22, 1		9. Birth Cou MARYI		Foreign
Maryland 21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. Ind other then "natural", or Itama 23s or 28s-f show event, Ira Medical Estandard mark to the traffic and	Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  MARYLAND  10b. County  ANNE ARUND  10c. Street and Number  4 ROSE STREET  11. Marital Status  1 Never Married  2 Married  3 Widowed 4 Divorced  15. Decedent's Ec (Specify only highest grade)  Elementary/Secondary (0-12)  11	12. Was Decedent Examed Forces?  1	16a. Deca (Give life.	10f. Zip Code	724  Hispanic Origiban, Mexican, o Specify:  upation to during most read)  YSIS INS	of working	y Yes or No- an, etc.)	UN1 14. Sp. Sind	n of What Cou TED STATI Race - Ameri Black, White, pecify: WH1* of Business/In	ean Indian, etc.	2 🗆 No
land	ed ita	To Be	17. Father's Name (First, Middle, Last) EDWARD O. KEEN					THOMP:	First, Middle, Mi SON	aiden St	imame)		
	9 = 2 -		19a. Informant's Name/Relationship ( MONA KEEN / W1FE	Type, Print)		ing Address (Stre STREET L		r or Rural R IARYLAN		City or T	own, State, Zip	Code)	
Baltimore,	permit. Pages 1 ar Department of Hea Important: If Item : any injury or other once.		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Specification of Fundamental Service Licer	()	METRO CREM	matory or other p	7	Date 7/22/20			tion - City or To		
Ba	Depa Impo any is		21. Signature of Pulled at Service Licer	is whi		LECK FUNE			ANDY SPRI	NC R	OAD LAUR	EL MD 207	707
D	Physician /Medical Examiner		23a. Part 1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	one cause on each line a. SEPSIS	he death. Do not en	ter the mode of d	ying, such as c	cardiac or re	espiratory arres	st,		Approximate Interval Betw Onset and D	reen
2/1	ouled nd ransit	Examiner	Sequentially list conditions, if any, leading to immediate causs. Enter Uncorping Cause (Disease or injury that initiated events	b. Due to (or as a	consequence of):								
8760,	cate be executed bhysician and the burial-transit	licai	resulting in death) Last		consequence of):								
P.O. Box 6	To the Hospital or Attending Physician: The law requires that the death certific: within 24 hours after death. within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending ploompletely filled in by the funeral director, page 2 should be detached for use as t	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	Fetal death 3	□Ectopic pregnar □ Other (specify)				230	d. Date of deliv Month	*	ear
	juires that n signed b	þ	Part II. Other significant conditions of DTABETES	ontributing to death but	not resulting in the t	underlying cause (	given in Part I.		23e. Did toba		contribute to t	he cause of de pably 4 🔲 Ur	
of Vital Records,	The taw requir cate has been s page 2 should	Completed	CORONARY ARTERY DISEAS	SE					24a. Was an autopsy perform 1 Yes 2	ed?	24b. Were auto prior to co death? 1  Yes		vailable use of
/ita	sician: The certificate rector, pag	Be (	25. Was case referred to medical examiner?						Check only one				
Ž	Physic this or	2	1 ☐ Yes 2 📉 No	Hospital: 1 Inpatient		nt 3 DOA	Other: 4 🗆 Nur	sing Home	5 🗌 Residen	ce 6 [	Other (Specia	(y)	
ion	nding Physician: ath. r: After this certific e funeral director,	ation:	27. Manner of Death  1 X Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time (	W	jury at /ork? □ Yes 2 □ N		d. Describe how	injury o	occurred		
Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fo	Certification:	3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, st (Specify)	reet, factory, offic	е	28f	Location (Stre City or Town,	et and f State)	Number or Rur	al Route Numb	ier,
	To the Hospita within 24 hours To the Funeral completely filled	edical (	29a. Certifier (Check only one)  1 \( \bigcirc Certifying Phromatology 2 \) 2 \( \bigcirc Medical Example 1)	ysician: To the best of niner: On the basis of e and manner state	examination and/or in	th occurred at the ovestigation, in my	time, date and y opinion, deatl	d place, and h occurred	due to the cau at the time, dat	rse(s) an e and pl	nd manner as s ace, and due t	tated. o the cause(s)	
	To th withir To th comp	Me	29b. Signature and title of certifier	TON MD		1	nse number	520		Date s	signed (Month,	Day, Year)	
	1 -		30. Name and address of person who		ath (Item 23a) /Typo		, 0 0 9	1)	1	1/2	0100		
	Ve		SRILATHA KANUMURU 73	00 VAN DUSEN I	ROAD LAUREL,								
8	Sta Registi		31. Date filed (Month, Day, Year)  JUL 2 4 20	32 Registrar									
DH	IMH 17 Rev 1/2	-1-1	00L N = 20	JAKENS.	JR A							<del>-</del>	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Ulexander each William 2006 1015AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Par If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) medical centr VA Baltimore BALTIMORE CITY 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 9. Birthplace (State or Foreign Days Director 216-09-2320 94 8, 1912 MAR. MARYLAND Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r than "natural", or Itema 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits MARYLAND ANNE ARUNDEL GLEN BURNIE Director 1 ☐ Yes XXNo 10e. Street and Number 10f. Zio Code 10g. Citizen of What Country? 112 MAIN AVE. S.W. 21061 Funeral UNITED STATES 12. Was Decedent Ever in U.S. Armed Forces? 1 X Yes 2 ☐ No If Yes, Give 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. WHITE filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 þ 1 ☐ Yes 2 X No Specify: Specify: 3 NWidowed 4 □ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry and Mental Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) ELECTRICAL HELPER U.S. COAST GUARD 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) . Pages 1 and 2 should be fill timent of Health and Mental H tant: If Itam 27 is marked off jury or other traumatic even Be WILLIAM A. LEACH ANNA RATHER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CHRISTINE JENNINGS / DAUGHTER 112 MAIN AVE. S.W. GLEN BURNIE, MD 21061 Baltimore. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State JULY Day 7, 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) GLEN HAVEN MEM. PK. 2006 GLEN BURNIE, MD 21. Signatur / Funeral Service Licenses k<sup>22</sup> Name and Addiess of Facility
FUNERAL HOME PA . MD 21061
421 CRAIN HWY. S.E. GLEN BURNIE, MD 21061 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** pheumonia /Medical Due to (or as a consequence of). Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physiclen and s the burial-transit death certificate be executed Due to (or as a consequence of): Box 68760. lcian/Medical for use as attending r IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2□Fetal death
4□Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 ☐ Other (specify) signed by the a d be detached f P.0. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? Records. δ Completed page 2 should 1 Yes 2 No 3 ☐ Probably 4 ☐Unknown peed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☒ No certificete has autopsy Division of Vital 2 No 1 ☐ Yes funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 200 P Inpatient this 2 ER/Outpatient 3 DOA 27. Manner of Death After t 28a. Oate of Injury (Month, Day Year) 28b Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred or Attending 1 Natural 5 Pending within 24 hours after death. To the Funeral Diractor: A investigation М 1 ☐ Yes 2 ☐ No 2 Accident the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital Medical 29a. Certifie 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. (Check only one) 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

And manner as stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) Heishinson P18568 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Jessica Hershenson Greene 32 Registrar's Signature Street. Baltimore 31. Date filed (Month, Day, Year) State JUL 24 2006 Registrar

DHMH 17 Rev 1/2001

**ORIGINAL** 

			For State Registrar	State of	of Maryl		artment of H rtificate of I		Mental Hygi	ene 20	06	23103
			1. Decedent's Name (First, Middle,	Last)					2. Date of Death	Davi	,	3. Time of Death
	Physici /Medio		Mary	Helen	]	Lineberg	er		Month uly	1 <sup>Day</sup> , 2006	ear	6:29AMM
1	Examin		4a. Facility Name (If not institution,	give street and nu	ımber)		4b. City, Town, or	Location of Death	1	4c. County of		
			Southern Maryl	land Hosp	oital		Clint	on		Princ	e Ge	orge's
Ŀ	Funeral Director		5. Social Security Number 578-92-2876	6.Sex 1 □ M 2 ∰ F	7. Age (In ) 73	yrs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth	Year)933 N	Birthpla County EW F	ace (State or Foreign ry) oundland
	P .		Usual Residence of Decedent		· · · · · · · · · · · · · · · · · · ·		-					
	show		10a. State 10b. County	0 1		. City, Town or Lo		1.1			10	d. Inside City Limits
	8a-1.	5	Maryland Prince	George's	5		Oxon Hi	. 1 1				1 ☐ Yes 2Ã☐ No
	th with the	al Dire	10e. Street and Number 5407 Virginia	Court			10f. Zip Code 20745	5	10	g. Citizen of Wh Cana		ry?
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylend Depertment of Health and Mentel Hygiene. Depertment of Health and Mentel Hygiene. Inportent: if Item 27 is marked other then "natural; or Items 23s or 28s-f show importent: if Item 27 is marked other then "healtest profiled Examinating or cother traumatic event, I'm Medical Examination in an once.	Be Completed by Funeral Director	11. Marital Status  1 Never Married 2 Marrie 3 Widowed 4 Divorced	12. Was Dec Armed F d 1 Tes If Yes, G Year or I	orces? 2∏No ive		Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 2 ☐ No	ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No- Rican, etc.)	14. Race - Black, Specify:	America White, e Whi	tc.
S O	72 ho	ted	15. Decedent's (Specify only highest		1		dent's Usual Occupa		kina 16	6b. Kind of Busi	ness/Indu	ustry
7	Par P	ple	Elementary/Secondary (0-12)	Ī -	1-4or 5+)	life.	DO NOT use retired	during most or world)	ang			
2	or th	Con	12			Hom	emaker			Home		
덜	el Hy	Be (	17. Father's Name (First, Middle, L.	ast)					e (First, Middle, Ma			
yla	ould to	ည	3	illies					ary Eliza			
, Maryland 21215-0036	and 2 shallh and 27 ie m		Joe G. Lineberge		and)				ral Route Number, o Oxon Hill			
ore	of He		20a. Method of Disposition 1 ☐ Burial 2 ∑∑Cremation 3	3 □Removal from	State		natory or other place	e) July	Date 20	oc. Location - Ci	ty or Tow	n, State
Ē	Pag ment: lury c		4 □ Donation 5 □ Other (Spe	ecify)	L	ee Crema	tory		006			Maryland
Baltimore,	Depermit Depermit Importing Supporting Suppo		21. Signature of Funeral Service Li	censes Sult		10	. Name and Addres $633~01 \mathrm{d}$		ee Funera a Ferry R			, MD 20735
			23a. Part 1. Enter the disease, or c shock, or heart failure. List o	omplications that	caused the deach line.	leath. Do not ent	er the mode of dying	g, such as cardiac	or respiratory arres	it,	í	Approximate nterval Between
	Physician		Immediate Cause (Final disease or condition	a My	ocard	ial Infa	rction					Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a con	sequence of):						
Н	¥	-	if any, leading to immediate cause. Enter Underlying	b. Ac	orașa con	erebral	Vascular	Accident				
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ó	en en erial-tr	Exa	resulting in death) Last			sequence of):	42242					
8760,	cate be executed physicien end the burial-transit	dlcal	\\	d. Cl	<u>ronic</u>	Obstruc	tive Pulm	monary Di	sease		_	
9	certific nding p use as	(D)	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, ou	tcome of pre	gnancy				23d. Date of	of deliver	,
Division of Vital Records, P.O. Box	The law requires that the death certifi site has been signed by the attending page 2 should be detached for use as	Physician/M	in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown		pirth 2   F nant at time own		Ectopic pregnancy Other (specify)			Month	,	ay Year
<u>ر</u> ٽ ص	res that igned b be deta	by PI	Part II. Other significant condition	s contributing to d	eath but not	resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribu	ute lo the	cause of death?
Ž	w require been sig should b	tedt	Insulin De	ependent	Diabe	tes			1 ☐ Yes	2 □ No 3	Probab	oly 4 Unknown
Reco	he law n e has be ige 2 sh	Completed							24a. Was an autopsy performe	d? dea	th?	y findings available otetion of cause of
Ē	in: T	ပိ	25. Was case referred to medical					26 Place of Door	1 ☐ Yes 2X	]No   1 □	Yes 2	□ No
>	s cer direct	0 0	examiner? 1 ☐ Yes 2 ☒ No	Hospital:	Inpatient 2	ER/Outpatien	t 317 DOA Othe	AC	ome 5 🗆 Residence	no 6 17 Other	(Canada)	
o uo	To the Hospital or Attending Physician: The law within 24 burus elite death. To the Funerel Director: After this certificate has completely filled in by the funeral director, page 2	tion: T	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date (Mon		28b. Time of	28c. Injury Work		28d. Describe how		<i>эрвспу)</i>	
isixi	or Atten tter deat irector: n by the	Certification:	2 Accident Investiga 3 Suicide 6 Could no 4 Homicide determin	t be 28e. Place	of Injury - A		eet, factory, office	20.00	28f. Location (Stre City or Town,	et and Number ( State)	or Rural F	Route Number,
۵	To the Hospital or A within 24 hours efter To the Funerel Directory illed in by		29a. Certifier 12 Certifying	Physician: To the	best of my	knowledge, death	occurred at the tim	e, date and place,	and due to the cau	se(s) and mann	er as stat	ed.
	the Hin 24 the Fu	Medical	1	and man	ner stated.	nination and/or inv			red at the time, date			
	5 ½ 5 g	~	29b. Signature and title of certifier	R-Edi	reun	Was m	29c. License	23 826	. 29d	I. Dale signed	3/1)	y, rear)
j	0		30. Name and address of person w	ho comple of cal	se of death (	Item 23a) (Type,	Print) B(MA	nen Ann	BONIC	livion	mn	20135
	Sta		31. Date filed (Month, Day, ¥aar)		Registrar's Si	gnature A	all 2	100.1106	VEI Y	111111	· · · · y	2/10
	Registr	ar	JUL 247	.006	Sifte of .	5-3" 150						

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State of Maryland / Department of Health and Mental Hygierie | 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2006 **Physician** July 15, Year F. Perry Linkins, Jr. 6:40AM M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Charlotte Hall Veterans Home Charlotte ual.

If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Sept. 2, 1931 St. Mary's 5 Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country)
New Jersey **Funeral X**□M 2□F 229-36-1680 74 Yrs. Director Usual Residence of Decedent the Maryland 10h County 10c. City, Town or Location 10d. Inside City Limits item 27 is marked other then "naturel", or Items 23s or 28s-f show other treumstic event. It's Medical Eventiner must be notified at 1 Yes 2 No Directo Maryland | Prince George's Clinton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 6309 Armor Drive U.S.A. 20735 death 12. Was Decedent Ever in U.S. Armed Forces? 1 TYPes 2 □ No 1952 If Yes, Give Year or Dates: 1954 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after of and Mental Hygiene. is marked other then "naturel", or Iter 1 Never Married 2 Married 1952-Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No by White 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Circulation Manager Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Perry F. Linkins, Sr. Louise Carter 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 is m any injury or other treum once. Jean Linkins (Wife) 6309 Armor Drive Clinton, Maryland 20735 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 20. 20c. Location - City or Town, State 1 🕅 Burial 2 🗆 Cremation 3 🗆 Removal from State Maryland Veterans Cem. Cheltenham, Maryland ' 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Funeral Service 22. Name and Address of Facility Lee Funeral Home , Inc. 70015 6633 Old Alexandria Ferry Road Clinton, MD20735 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Due to for as a consequence of): Physician disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner use as the burial-transit resulting in death) Last Due to (or as a consequence of): the attending physician Division of Vital Records, P.O. Box 68760 requires that the death certificate be Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Nnknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 🗆 No 1 TYes 21/2 Hospital or Attending Physician: 26. Place of Death (Check only one) examiner' 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) Other: 1 ☐ Yes 2 🗶 No 1 Inpatient 2 ER/Outpatient 3 DOA After this funeral c 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 28b. Time of 28d. Describe how injury occurred 5 Pending within 24 hours after death. To the Funerel Director: A 1 ☐ Yes 2 ☐ No 2 Accident investigation 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) D 12070 Old Line Centre #207 Waldorf MD 20602-2567 30. Name and address of person wh Louis Kaufman MD

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Registrar

31. Date filed (Month, Day, Year)

2 4 2006

32 Registrar's Signature

		State Registrar				C	ertificate	or Dea		1000000	Reg. No.		
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al		5. Social Security Number	6. 9	Sex	7. Age (In yrs	. last birthda	ay) If Under 1 Y	Year I If Un	der 24 Hrs.	8. Date of B	irth	9. Birth	hplace (State or Fore
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	era	2214 Lake Drive		12. Was Dec	edent Ever in l	U.S. 1	3. Was Deceden If Yes, specify	1122 It of Hispanio	Origin? (Sp	ecify Yes or N	0- 14	USA Race - Amer	
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	Be	17. Father's Name (First, M.	iiddie, Lasi	1)				18. M	iotner's Nam	e (First, Middle	e, Maiden Si	ırname)	
1	ပ္	Mark Lowder		(Toron Orient)		405.44	-111 4 -1 (7)		herine		017		Tin (0 - /n)
		19a. Informant's Name/Rela					ailing Address (S				_	own, State, Z	up Code)
		Gerard Lowder 20a. Method of Disposition	So	ın	20b.	_	Lake Dri			, MD 2112 <sub>Date</sub>		tion - City or	Town, State
		1XXBurial 2 ☐ Crema			State	cemetery, c	rematory or othe Cemetery	er place)	7-26-0	06			
	-	`4 □Donation 5 □ Oth  21. Signature Funeral Se					22. Name and A	Address of E	acility		Lynanu	rst, NJ	
once		AL Gregory	ليبه	M01148			Fink Fun	eral Ho	ome, P.A	burnie,	MD ZIU	**	
al er		Immediat Cause (Final disease or andition resulting in death)	ſ	Due to	Or as a conse	auonaa aft:	ARCING	DID T	umo				Approximate Interval Between Onset and Death
er	Examiner	Sequentially list conditions, say, see that underlying Cause, Disease or injury that initiated events resulting in death) Last	{	Due to Due to	(or or a copro	equence of):	ARCING	DID T	umo	12			Interval Betweer Onset and Deati
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ORIGINAL

DHMH 17 Rev 1/2001

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

		•	For State Registrer	ate of Maryland /	Departme Certifica				giene 20	06 2	3   06
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Year 3. Ti	ime of Death
	Physici /Medic	p.0	Catherine Arleen No	orth				July	210	2006 11	15 a. M.
	Examin		4a. Facility Name (If not institution, give street	1 / 2	4b. Cib	Town, or I	Location of Death		4c. County	of Death	
			St. Ugnes Heal	th Care	List is a lift lad	OU+ er 1 Year	If Under 24 Hrs.	0.5		0.00	
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last I	Yrs. Months		Hours Min.	8. Date of Birt (Month, Da)	v, Year)	9. Birthplace (S Country)	
	Director		215-30-9745 Usual Residence of Decedent	72			5	ept.14	,1933	Marylan	d
	yland		10a. State 10b. County	10c. City, To	wn or Location						ide City Limits
	a-f el	cto	Maryland Baltimore	Cat	onsville					10	Yes 2 No
	ith thi	Directo	10e. Street and Number		10f. Z	ip Code			10g. Citizen of V	Vhat Country?	
	eth w	-B	16 Fusting Avenue			2122			USA .		
	er de	Funerai	Ar	as Decedent Ever in U.S. med Forces?	13. Was Dec	edent of His ecify Cuban	panic Origin? (Spec , Mexican, Puerto R	offy Yes or No- lican, etc.)	14. Race Blac	e - American Indi k, White, etc.	an,
36	rs aft	by F	1 Never Married 2 Married 1 If If 3 Widowed 4 Divorced Ye	□Yes 2127No Yes, Give ear or Dates:	1 ☐ Yes	2 No	Specify:		Specify	White	
Ş	2 hou	ed	15. Decedent's Education	16	a. Decedent's Us	ual Occupat	tion		16b. Kind of Bu	siness/Industry	
215	hin 7.	Completed	(Specify only highest grade com Elementary/Secondary (0-12)	ollege (1-4or 5+)	life. DO NOT	use retired)	uring most of workin	9			
21	ed wit	TO I	12		Claims	Repre	esentative	2	Gover	nment	
p	2 should be filed within 72 hours after deeth with the Maryland and Mental Hygiene. Is marked other than "natural; or items 23a or 28a-f show aumatic event, it a Medical Exantrier must be notified at	Be	17. Father's Name (First, Middle, Last)				18. Mother's Name	(First, Middle,	Maiden Sumam	Θ)	
<u> </u>	ould Men Marke Marke	٦	Harry C. Manger				Hester Ke				
Mar	12 sh h and 7 ie m traum	S 5	19a. Informant's Name/Relationship (Type, Princhael A. North	·			nd Number or Rural Ridge Roa				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should Department of Health and Men Important: if Item 27 is marke any injury or other traumatic.		20a. Method of Disposition							City or Town, Sta	
jo	Pages nent of I int: if it		1 Burial 2 ☐ Cremation 3 ☐ Remov	ai irom State	of Disposition (Natery, crematory or		!				46
臣	it. P.		4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licensee,	Lorra	ine Parl	K and Address	7/26/	12006	Woodlaw	n, Maryl bwab Wii	and
Ba	permit. Departe Imports any inj once.		Vihon: Or	V S	Fune	ral Ho	of FacilitySter ome of Ca ndson Ave	tonsvil	lle, Inc.	Lo Mu	21228
		7	23a. Part1. Enter the disease, or complication shock, or heart failure. List only one cau	ns that caused the death. De					A COLUMN TO SECURE	Appro	ximate
	Physician		Immediate Cause (Final	ise on each line.	f.					Onset	al Between and Death
	/Medical		disease or condition resulting in death)	Due to (or as a consequenc	e of):		0 ,		Δ	7	wein(
	Examiner		Sequentially list conditions	hronic E	bitru	cti	ve Pu huy	an ele	, Dire	tile 2	760-3
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B	eath etten for u	cian	in the past 12 months?	Live birth 2 Fetal dea	th 3 Ectopic :				Mor	,	Year
, Jo.	that the de led by the de detached	ysi	9 ☐ Unknown 9	Unknown		,,,,					
平	signed b	by P	Part II. Other significant conditions contribut	ing to death but not resulting	in the underlying	cause giver	n in Part I.	23e. Did to	bacco use contr	ibute to the caus	e of death?
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₹ <b>œ</b>	lan: The law rtificete has l tor, page 2 s	Completed						autop perfor	med? d	rior to completion eath? Yes 2 No	n of cause of
Tian I	ilcian: Th certificate rector, pag	Bec	25. Was case referred to medical examiner?				26. Place of Death	1			
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n o	ing P		27. Manner of Death 1 XNatural 5 ☐ Pending	a. Date of Injury 28b (Month, Day Year)	. Time of Injury	28c. Injury a Work?		Bd. Describe h	ow injury occurre	ed	
Sio	tend seath tor: /	cati	2 Accident investigation 3 Suicide 6 Could not be	Discontinuo Albana	M		es 2 □No	26 Lanation (C			A1
Division	or At after c Direc in by	Certification:	4 Homicide determined 286	e. Place of Injury - At home, building, etc. (Specify)	iarm, street, lacto	огу, опісе	28	City or Tow	itreet and Numbe n, State)	er or Hurai Houte	Number,
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: Atter this certificate h completely filled in by the funeral director, page		29a. Certifier 1 Certifying Physician	: To the best of my knowled	ge, death occurre	d at the time	, date and place, ar	nd due to the c	ause(s) and mar	nner as stated	
	• Hos 24 h • Fur letely	Medicai	(Check only 2 Medical Examiner: C	On the basis of examination and manner stated.	and/or investigation	on, in my opi	nion, death occurred	d at the time, o	date and place, a	nd due to the ca	use(s)
_	Within To th comp	Me	29b. Signature and title afcertifier	1	25	9c. License			29d. Date signed	(Month, Day, Ye	ear)
			1 1V8 A.	1000		DO	0273	15	July.	$\lambda 1, 2$	006
	10		30. Name and address of person who complet	led cause of death (Item 23a	i) (Type, Print)	pa 1	0273	1/	25-7	1/.7	11.
	6		MUTIGLE.	2 bory n	np	19.	Mane	on	13/2. 4	a/, /sa	14 mag
	Sta Registr	te	31. Date filed (Month, Day, Yeal) JUL 2 4 2006	32. Registrar's Signature	cooser		U		V	/	
	negisti	ar	30L W =								

06-04656 Nora Powell

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Cei	rtificate of Death		g. No. 200	06 2310
Physici ledical Exam		1. Decedent's Name (First, Middle,	//	-1/	2. Date of Deat Month	Day Year	3. Time of Death 0710 hrs
neulcai Laami	mei	NORA HA  4a. Facility Name (if not institution,		4b. City, Town, or Lo	July 3, 200	4c. County of Death	
		2124 East Oliver Street	•	Baltimore			`
Funeral		UNK	. Sex 7. Age (In yrs. I	ast birthday) If Under 1 Year  Months Days	If Under 24Hrs. 8. Date of Birt Hours Min.	h(MM/DD/YYYY) 9. Bir Foreig	in.
Director			M 2 F 34	Yrs. World's Bays	10-15	-1971 Co	untry) MARYLAND
any		Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Location			10d. Inside City Limits
Maryland 28a-f show any d at once.	٦	MD	BA	LTIMORE			1 XYes 2 No
Maryla 28a-f d at ou	Director	10e. Street and Number		10f. Zip Code		g. Citizen of What Cou	ntry?
th the Maryland 23a or 28a-f sho notified at once	ral Di	2124 E- OLIV		212		USA	
eath wi	uner	11. Marital Status 1 Never Married 2 Marr	12. Was Decedent Ever in U Armed Forces?		nic Origin? ( Specify Yes or No- lexican, Puerto Rican, etc.)	14. Race - Ameri White, etc.	can Indian, Black,
after de al", or ner m	by Fu	3 Widowed 4 Divor	1 Yes 2 No	1 Yes 2 No s	specify:	Specify:	LACK
hours : natura Exami	ᄝ	15. Decedent's Education (Specification)	only highest grade completed)	16a. Decedent's Usual Occupation during most of working life. D	(Give kind of work done	16b. Kind of Business/l	Industry (UNK)
36 nin 72 e. Ithan "dical J	Complete	Elementary/Secondary (0-12)	College (1-4 or 5+)	<b>g</b>	and the second		
5-00 ed with lygiene other	Com	17. Father's Name (First, Middle, L	ast)	( UNK 18	.Mother's Name (First, Middle, N	faiden Surname)	(UNK
21215-0036 uld be filed within 7 Mental Hygiene. marked other than c event, the Medical	Be						`
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mornell Hygiers (Important: If item 73 is marked other than "matural", or items 23a or 28a-f she important: If item 73 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once	P.	19a. Informant's Name/Relationship  MONIQUE BAI		19b. Mailing Address (Street a	nd Number or Rural Route Num	ber, City or Town, State	, Zip Code) 2/2/3
ore, MD ss 1 and 2 sho of Health and If item 27 is	10	20a. Method of Disposition	20b.	Place of Disposition (Name of ceme		20c. Location - City or	
MOF Pages ent of nt: If		1 X Burial 2 Cremation 4 Donation 5 Other Spec	3 Removal from State	crematory or other place)	Ru 7-12-06	BAITIMOR	E, MD.
Baltimore, permit. Pages I ar Department of Hee Important: If ite	=	21. Signature of Funeral Service Li	censee	INITY CENETED  12. Name and Address of	Facility PHILLIF H. W.	ENTHENFORD F	UNERAL SERVICE
	V ()	CANGE HUNCEL	FO.	2431 E. OLIVE	ER ST. BALTIMO	RE, MD, 212	
Physician /Medical	1.4	23a. Part I. Enter the disease, or confailure. List only one cause or	each line.		cn as cardiac or respiratory arre	st, snock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Pulmonary Thromboem  Due to (or as a consequence o				Deau
	<u>.</u>	Sequentially list conditions,	b.	£).			
	Examiner	if any, leading to immediate cause Frite Uncertying Cause (Disease or injury that initiated	Due to (or as a consequence o	1);. 			
led insit	Exal	events resulting in death) Last	Due to (or as a consequence of	f):			
760, cate be executed physician and the burial - transi	ical	UNPENDED	x AMENDED item#26,	perVerbalME,C857,7/24	+/06 TT		
68760, certificate be ex nding physician se as the burial	/Medical	IF FEMALE:	23c. If yes, outcome of preg	nancy	178	23d. Date of delivery	,
Ox 68; sath certifi attending or use as I	sician	23b. Was decedent pregnant in the past 12 months?	1 Live birth Pregnant at time of		Ectopic pregnancy	Month D	Day Year
leat for	Physi	1 Yes 2 No 9 V Unkno	wn g death Unknown				
P.O. E res that the c signed by the be detached	by P	Part II. Other significant condition	ns contributing to death but not re	esulting in the underlying cause give		pacco use contribute to	
ts, Fauires		Obesity	<del></del>		24a. Was a	2 No 3 Prob	topsy findings available
Records, The law require	Completed		***		autops	y prior to c	ompletion of cause of
tal Recision: The certificate ector, page		25. Was case referred to medical		26 Place of	1 ✓ Yes 2 Death (Check only one)		s 2 No
of Vital ng Physician: After this certi	To Be	examiner?  1 ✓ Yes 2 No	Hospital: 1 Inpatient 2			Residence 6XX Other	at scene
n of ing Ph		27. Manner of Death	28a. Date of Injury (Month, Day, Year)	28b. Time of Injury 28c. Injury a		ow injury occurred	de Beale
Sion Attend death. ctor:	catic	Natural 5 Pending Accident Investig	ation		2 No		
Division pital or Attendino ours after death.	Certification:	3 Suicide 6 Could r	ot be	ome, farm, street, factory, office build	ding, etc. 28f. Location (Si or Town, St	treet and Number or Ru ate)	ral Route Number, City
e Hospi n 24 hour e Funer letely fill		20a Certifier		ge, death occurred at the time, date	and place, and due to the cause	(s) and manner as start	ed
Divis  To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b	edical			nd/or investigation, in my opinion, de			
. > - 0	ž	29b. Signature and title of certifier	(10	29c. License n		29d. Date signed (Mor	th, Day, Year)
	ļ	Colill	2715	O.C.M.I	E.	July 3, 2006	
1		30. Name and address of person what Zabiullah Ali, M.D. As	o completed cause of death (Item sistant Medical Examiner	23a) 111 Penn Street, Baltime	ore, MD 21201		
St	ate	31 Date filed (Month Day Year)	32. Segistrar's Signatu	re A			
Regist	trar	JUL Z 4 Z	006 Lines L	Appelle			

06-05103 Jesse Peoples

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certific	ate of Dea	ath	na. r rygrerii	Reg No	20	06 2310
Physicia Medical Exami	an/	Decedent's Name (First, Middle,Last)     Jesse		People	es	Mont	of Death	Year	3. Time of Death 1414 hrs
)		4a Facility Name (if not institution, give street and nur Johns Hopkins Hospital	nber)		, Town, or Location			c. County of De	eath
Funeral Director		218-58-6391 1XM 2_F	7. Age (In yrs. last bir	· ·	nder 1 Year If Und hths Days Hou		e of Birth(MM 2-28-19	1_	Birthplace (State or reign Country) Md.
, any		Usual Residence of Decedent  10a State 10b. County	10c City, Town	or Location					10d Inside City Limits
Maryland 28a-f show 1 at once.	ctor	Md. NA	В	altimore	Zip Code		10a Ci	tizen of What C	1 Xves 2 No
th the Maryland 23a or 28a-f sho notified at once.	I Director	5702 Van Dyke Road			21239			US	
hours after death with the Maryland natural", or items 23a or 28a-f she Examiner must be notified at once	y Funeral	11. Marital Status 1 Never Married 2 Married Armed Fo 1 Yes 3 Widowed 4 Divorced If Yes, Give Year	edent Ever in U.S. rces? 2 XNo	If Yes, spe	dent of Hispanic O ecify Cuban, Mexica 2 X No specif	n, Puerto Rican, e	s or No- tc.)	14 Race - An White, etc	
61 3 🛄	Completed by	15. Decedent's Education (Specify only highest grade  Elementary/Secondary (0-12) College (1-8th grade			al Occupation (Give vorking life. DO NO Clerk		e 16b.	Kind of Busine	
5-0C ed wil lygien other	Be	17 Father's Name (First, Middle, Last)  Jesse J.		Peoples,	Sr. 18.Moth	er's Name (First, M O <b>retta</b>		Surname) Conn	or
ore, MD 2121! Soland 2 should be fill of Health and Mental I If item 27 is marked ther traumatic event, the	٩	19a. Informant's Name/Relationship (Type, Print )  Karen Hodge-Peoples	Wife	b. Mailing Address 5702	ss (Street and Nu Van Dyke	mber or Rural Rou Road,	ute Number, C Baltimo		ate, Zip Code)
ages I and 2 shount of Health and It: If item 27 is rother traumatic		20a. Method of Disposition  1	m State crema	tory or other pla	,	Date			or Town, State
Baltimore, permit. Pages I at Department of He Important: If ite		Donation 5 Other Specify: 21. Agenture of Funeral Service Licensee	I KI		. PK. nd Address of Facil <b>ch F.H.</b>	,	Bal		stown, Md. Md. 21202 h Ave.
Physician /Medical		Part I. Enter the disease, or complications that can failure. List only one cause on each line.  Immediate Cause (Final disease a Cardi	used the death. Do n ac arrythmia				tory arrest, sh	ock, or heart	Approximate Interval Between Onset and Death
xaminer		or condition resulting in death)  Due to (or as a	consequence of):	· dae ee e	araranjopat				
	Examiner	Cause. Enter Underlying Cause (Disease or injury that initiated	consequence of);						
760, icate be executed g physician and the burial - transit		d d AMENDED	** #20 DI	T 07 M	F. 050 0 /10	loc m		· · · · · · · · · · · · · · · · · · ·	
		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, o 1 Live bii 4 Pregna	ant at time of death		th 3 Ector		23	3d. Date of delive Month	very Day Year
, P.O. Baires that the de signed by the		Part II. Other significant conditions contributing to		ng in the underly	ng cause given ın f	Part I. 23e			to the cause of death?
rds, P requires the	ted by	Cocaine use				24a	Yes 2		Probably 4 Unknown
Division of Vital Records, P.O. Box 68 tal or Attending Physician: The law requires that the death certi rs after death.  "I Director: After this certificate has been signed by the attendin led in by the funeral director, page 2 should be detached for use as	Completed	25. Was case referred to medical	·		26 Place of Depti		autopsy performed? Yes 2 1	prior	to completion of cause of
Vita  hysician this cert	o Be	examiner?	patient 2 🗸 ER/C	Outpatient 3	DOA Other	Nursing Home		ence 6 O	ther:
ivision of Violes or Attending Physicafter death. Director: After this I in by the funeral dir	Certification: 1	Natural 5 Pending Accident Investigation	Day,Year)	Time of Injury	28c. Injury at Wo	No	scribe how in		
Divis pital or A ours after eral Dire filled in b	Sertific	3 Suicide 6 Could not be determined (Specify)	of Injury - At home, f	arm, street, facto	ory, office building,		ation (Street own, State)	and Number or	Rural Route Number, City
Divis  To the Hospital or An within 24 hours after of To the Funeral Direct completely filled in by	Medical (	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of and manner str	f examination and/or						
	Š	29b. Signature and title of certifier  Purple A without MO			O.C.M.E.	r		Date signed (	Month, Day, Year)
X		30 Name arkt address of person who completed cause Pamela Southall, MD Assistant Med	of death (Item 23a)	111 Penn	Street, Baltimo	re, MD 21201			
St Regist	ate rar	1111 0 4 2000	gistrar's Signature			<del>.</del> .		_	
DHMH 17 Rev 1/20	_	ANT 10 4 70/101	Creus Di	RIGUNAL	U	·			<del></del>

DHMH 17 Rev 1/2001 OCME 2006

			For State Registrar	State o	f Marylan		artment o rtificate	f Health and of Death	d Mental H	ygiene Reg. No.	2006	23109
	Physic		Decedent's Name (First, Mid     MAGDALINE A. PAR						2. Date of I	Day	2006	3. Time of Death
	/Medi Examir		4a. Facility Name (If not instituti CATON MANOR	on, give street and nui	mber)		4b. City, Tow	n, or Location of D		4c. (	County of Death	
	Funeral Director		5. Social Security Number 219–28–2165	6. Sex 1 ☐ M 2 ☐ <b>X</b> F	7. Age <i>(In yr</i> s. <b>71</b>	last birthday) Yrs.	If Under 1 Ye Months Da		Hrs. 8. Date of E	Day, Year)	Cour	
	and w		Usual Residence of Decedent  10a. State 10b. Coun	ty	10c. Cit	ty, Town or Lo	cation				1	0d. Inside City Limits
	Maryi	ţ	MARYLAND NA			BAI	TIMORE					1 X Yes 2 ☐ No
	th with the 23a or 28a let be not	al Direc	10e. Street and Number 923 GTLMOR STREET	2			10f. Zip Coo	21217		-	zen of What Cour USA	ntry?
9800	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at ance.	d by Funeral Director	11. Marital Status 1 □ Never Married 2 □ Ma 3 ➡ Widowed 4 □ Divorce	Armed Fo arried 1 ☐ Yes If Yes Giv	2 <b>™</b> No ⁄e		Was Decedent f Yes, specify (	of Hispanic Origin? Cuban, Mexican, Pi No <i>Specify:</i>	(Specify Yes or I uerto Rican, etc.)		4. Race - Americ Black, White, Specify:	
21215-0036	within 72 h ane. than "natu	Completed	(Specify only high Elementary/Secondary (0-12)		-4or 5+)	(Give	DO NOT use re	ne during most of	working	EL PO	of Business/Ind	
	Hygie Hygie other	ပိ	11 17. Father's Name (First, Middle	NA o. Last)		FOOD F	IANDLER	18. Mother's	Name (First, Midd			T COMMISSARY
an	should be filed within a Mental Hygiene. marked other than matic event, that the	To Be	JAMES F. JONES						ET CROMWELL		,	
Maryland	1 and 2 should Health and Men tam 27 is marke other traumatic	1	19a. Informant's Name/Relation	nship (Type, Print) SON 4	<u> </u>		ng Address <i>(Str</i>	eet and Number of	Rural Route Num			Code)
Baltimore,	permit. Pages 1 and 2 Department of Health a Important: If itam 27 li any injury or other tra ance.		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other		State	Place of Disponentery, cremetery, cremetery	sition (Name of matory or other ATORY	place)	Date 7 26, 2006		cation - City or To	
Balt	pemit. Departr Imports any inju		21. Signature of Funeral Service	e Licensee	<b>S</b>			dress of Facility				
*	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, shock, or heart failure. Li immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. ME7.  Due to (	ach line.	uence of):  TAC uence of):	CER	VICAC RENF THR	C PL D	ANC		Approximate Interval Between Onset and Death MonUse
Box 68760,	The law requires that the death certificate be executed site hes been signed by the attending physician and a sage 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	d	come of pregna irth 2 □ Feta ant at time of d	ancy	Ectopic pregna			23	3d. Date of delive Month	ry Day Year
s, P.O	es that the de igned by the a be detached to	þ	9 ☐ Unknown  Part II. Other significant condi	1		ulting in the u	nderlying cause	given in Part I.				e cause of death?
Records,	e law require hes been sig je 2 should b	Completed							24a. Wa	s an		osy findings available
<u>=</u>	The l	Con							per 1 ☐ Yes	formed? 2☐No	death? 1 ☐ Yes	2□ No
Vital	ysician: Th is certificete director, pag	Be	25. Was case referred to medic examiner?	Hospital:					Death (Check only			
of	Phys this al dir	ဥ	1 ☐ Yes 2 ☐ M6  27. Manner of Death	101		ER/Outpatien 28b. Time of	t 3 DOA	Other: 4 Nursin	g Home 5 ☐ Re: 28d. Describe			"
Division	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director,	Certification:	1 Natural 5 Pend 2 Accident inves 3 Suicide 6 Coul	tigation and hot be	of Injury th, Day Year) of Injury - At ho	Injury	M 1	njury at Work? I □ Yes 2 □ No		. ,	Number or Rural	I Route Number
Οįς	To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by		4 _ nomicide	ing Physicien: To the	ng, etc. (Specif	y) 			City or To	own, State)		
	To the Hospital within 24 hours a To the Funeral I completely filled	Medical	(Check only 2 Medics one)	al Exeminer: On the ba and man	asis of examina	tion and/or inv	estigation, in π	y opinion, death o	ccurred at the time	, date and p	place, and due to	the cause(s)
	5 <u>7 × 7</u> 8		29b. Signature and title of certif	on te	MD		D	ense number	3 150	50	signed (Month, L	
	H		30. Name and address of perso				Print)	0 5A0	( A -	000	SUI	175110 175110 -UMBIA
	Sta Registr		31. Date filed (Month, Day, Yea JUL 2 4 2)	r) 32. R	egistrar's Signa	PTA		U 340	VIITCE (	JAL	COL	ZICYT
DH	MH 17 Rev 1/2	_		- Color	w M	Month						

			1- For State Registrar	e of Marylar		artment of I		Mental Hy	/giene	06 23110
	Physic /Medi		1. Decedent's Name (First, Middle, Last)	DITH	Rou	uE		2. Date of D Month	eath Day	Year 3. Time of Death
	Exami		4a. Facility Name (If not institution, give street an Fox Chase Rehab & Nurs	sing Cente	er	4b. City, Town, Silver	or Locetion of De Spring	ath		ty of Death Comery
	Funeral Director		5. Social Security Number  579-34-0199  Usual Residence of Decedent  6. Sex 1 □ M 2 ☑	7. Age ( <i>in yrs</i> . 77	last birthday) Yrs.	If Under 1 Year Months Days			rth 1928	9. Birthplace (State or Foreign Country) Virginia
	within 72 hours after death with the Maryland one. than *natural; or Items 23a or 28a-f show tha Madical Examitter frank be notified at	Funeral Director	DC 10a. State 10b. County DC 10e. Street and Number		ty, Town or Lo Washin	gton 10f. Zip Code			10g. Citizen of	10d. Inside City Limits  12€ Yes 2 □ No  What Country?
036	should be filed within 72 hours after death with the Marylan nd Mental Hygiene. marked other than "natural", or Items 23a or 28a-f show marked other than "natural", or Items 20a or 20a-f show marke event, the Madical Examination.	þ	1 Never Married 2 Married 1 1 15 16 Yes	N. E. ∦ 8  Decedent Ever in U ed Forces?  Yes 2 ⊠ No s, Give or Dates:		2001 Was Decedent of I f Yes, specify Cub	Hispanic Origin? ( an, Mexican, Pue	Specify Yes or No erto Rican, etc.)		ce - American Indian, ack, White, etc. fy: Black
Maryland 21215-0036	id within 72 hoi giene. er than *natura , the Madical I	Completed	15. Decedent's Education (Specify only highest grade comple  Elementary/Secondary (0-12)  1 2  Colle	ered) ege (1-4or 5+)	(Give life. L	lent's Usual Occup kind of work done DO NOT use retire tic Work	during most of w	orking		Business/Industry
yland	should be filed and Mental Hygies marked other umatic event, II	e	17. Father's Name (First, Middle, Last) Lorenzo J. Golden				Rosa L.	ame (First, Middle Carter	, Maiden Suma Golden	me)
ď,	es 1 and 2 of Health a fitem 27 is r other trau		Harry O. Stinson, II / 20a. Method of Disposition  1월 Burial 2 □ Cremation 3 □ Removal f	Son 20b. P	7051 Place of Disposemetery, creman LICO		Blvd.,	Orlando. Date	FL 32 20c. Location	818 - City or Town, State
Baltin	permit. Pag Department Important: I any injury o		21. Signature of Funeral Service Licensee	4.11	La		ess of Facility Funeral I	Home Wasl	Georgi nington	a Avenue, N.W.
	Physician /Medical		23a. Parti. Enter the disease, of complications shock, or heart failure. List only one cause Immediate Cause (Final disease or condition resulting in death)  Due	Marcalused the death on each line.  Chronic e to (or as a consequ	Kidney			ac or respiratory a	rrest,	Approximate Interval Between Onset and Death 6 Months
	certificate be executed  X Iding physician and Ise as the burial-transit	dical Examiner	Cause (Disease or injury that initiated events c.	e to (or as a consequence to (or as a consequence)						
	y the atter	Physician/Me	in the past 12 months?  1☐ Li  Yes 2 ☒ No.	, outcome of pregnai ive birth 2 □ Fetal regnant at time of de Inknown	death 3 I	Ectopic pregnancy Other (specify)	,			te of delivery nnth Day Year
ras, r	w requires that been signed b should be deta	ğ	Part II. Other significant conditions contributing Hypertension		ulting in the und	derlying cause giv	en in Part I.			ribute to the cause of death?  3 □ Probably 4 ⊠Unknown
L Kec	ine taw ate has b page 2 sl	Completed	Atrial Fibri Coronary Art		se			24a. Was autop perfor 1 🗆 Yes	rmed?	Mere autopsy findings available orior to completion of cause of death? □ Yes 2 ② No
ion of vital	within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, pag	ation; To Be		Inpatient 2 E ate of Injury Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Injun Worl	er: 4X Nursing I	ath (Check only of dome 5 Residence 1986). Describe h		
DIVISION	within 24 hours after death To the Funeral Director: completely filled in by the	Certification;	4   Homicide bi	lace of Injury - At hor uilding, etc. (Specify,	·)			City or Tow	n, State)	er or Rural Route Number,
1	hin 24 hou the Fune npletely fil	Medical		the best of my known ne basis of examinati nanner stated.	vledge, death of inve	estigation, in my or	oinion, death occu	urred at the time, o	date and place, a	and due to the cause(s)
ŕ	Twit		29b. Signature) and title of certifier			D286			July 13	, 2006
		:22	30. Name and address of person who completed of Ravi Passi, MD 8609 2 31. Date filed (Month, Day, Year)	cause of death (Item 2nd Avenue 2. <b>Re</b> gistrar's Signatu	e; Suit	e 404B;	Silver S	Spring, N	1D 20910	)
	Stat Registra		1111 2 4 2006	A Salar A	the April	artis.				

06-05236 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Jason Bradley Simms 1- For State Certificate of Death Registrar 2. Date of Death 1. Decedent's Name (First, Middle, Last) Physician/ Month Day July 20, 2006 0716 hrs **Medical Examiner** Simms Bradle lason 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number) Baltimore County 3900 Milford Mill Road Lochearn 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. **Funeral** Foreign Hours Director Country) MO 1 4M 2 F January Yrs Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d Inside City Limits 1 Yes 2 No MD Raltimore traumatic event, the Medical Examiner must be notified at once. Director 10g. Citizen of What Country? 10e. Street and Numbe 21230 312 Scott Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black 11. Marital Status Was Decedent Ever in U.S. White, etc 1 Never Married 2 Armed Forces? Married African Yes other than "natural", or Yes 2 No specify. Widowed 4 Divorced If Yes, Give Year Specify à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) MD 21215-0036 Analysis 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) of Health and Mental F Be Simms 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) မှ ochearn MD 21244 Mother Victoria Avenue 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Burial 2 Cremation 3 Removal from State memorial Park July 24, 2006 mportant: Department Donation 5 Other Specify or c Name and Address of Facility
Hav. P- Close Funenal
5126 Belain Road 21. Signature of Funeral Service L Service, P.A. 21206 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear Approximate Interval **Physician** 8etween Onset and failure. List only one cause on each line /Medical Death a Contact ShotGun Wound of Head Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last and Physician/Medical tending physician are use as the burial -AMENDED UNPENDED of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE: 23d. Date of delivery 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I ģ 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed ✓ Yes 2 1 🗸 Yes To the Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) Be Hospital: 1 Other<sub>4</sub> Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 🗸 Other. Scene ij မှ 1 🗸 Yes 28a. Date of Injury FOUND: Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification Subject shot self **FOUND** Division Natural Yes 2 V No 5 Pending Jul 20, 2006 0716 hrs Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc. 3 V Suicide Could not be or Town, State) 3900 Milford Mill Rod, Lochearn, MD within 24 hours a

To the Funeral L determined (Specify) Swim Club Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started. 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29d. Date signed (Month, Day, Year) 29c. License numbe 29b. Signature and title of O.C.M.E July 21, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Susan Hogan MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar **ORIGINAL** DHMH 17 Rev 1/2001

			1- State #31& RegistrarAmend #10e P	State of Marylater FH G857	and / Depa 7/24/66 <sup>9</sup>	artment of I tificate of	Health and <i>Death</i>		giene (	16	23112
	Physici	an	Decedent's Name (First, Middle, Last)					2. Date of Dea Month	Day	Year	3. Time of Death
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	Funeral Director		5. Social Security Number 6. Sex 212-32-7392	7. Age (In y	rs. last birthday) Yrs.	If Under 1 Year Months Days	Hours Mir	. (Month, Day	Year) 4 36	9. Birthplae Country M I	ce (State or Foreign
	and		Usuel Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				100	f. Inside City Limits
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	or 284	Oirec	10e. Street and Number Heigh	ts		10f. Zip Code		1	0g. Citizen of W	/hat Country	y?
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036	permit. Pages 1 and 2 should be filed within 72 hours atter death with the Maryland Department of Health and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itams 23e or 28e-f ahow ampting they or other traumatic avent, Ins Medical Examinar must be neitling an once.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ Widowed 4 ★ Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2000 Nio If Yes, Give Year or Dates:		Was Decedent of the fives, specify Cub	dispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No- rto Rican, etc.)		e - American k, White, etc	
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<u>d</u> 2	Hygir other	Be Co	12th grade  17. Father's Name (First, Middle, Last)	2yrs	Flai	ic mana		ame (First, Middle, I	Corp. Maiden Sumame	e)	
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Maryland	2 sho		19a. Informant's Name/Relationship (Ty)	pe, Print)				Rural Route Number			ode)
e)	1 and Health am 27		Shaun N. Snell- 20a. Method of Disposition		3504 o. Place of Dispo		ey Rd,	Baltimo	re, Md 20c. Location - 0		215
Ē	Pages nent of nt: If It		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☑ Donation 5 ☐ Other (Specify)		cemetery, cren	natory or other pla	ce)		Loo. Loodion	only or rown	i, State
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	•		23a. Part1. Enter the disease, or compli- spock, or heart failure. List only on	cations that caused the de e cause on each line.	eath. Do not ente	er the mode of dyir	ng, such as cardia	ac or respiratory arre	est,	. In	pproximate iterval Between
	Physician /Medical Examiner	_	Immediate Cause (Final disease or Cendition resulting in death)  Sequentially list conditions.	Due to (or as a cons	11/2/11	hac dea Disea	15				nset and Death
68760,	icate be executed physician and ithe burial-transit	dical Examiner	n any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	47 18	n/qt-ci	h/-				
		<b>a</b>	IE SELVIE		_						
P.O. Box	The law requires that the death certificate has been signed by the ettending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 □ Live birth 2 □ Fo 4 □ Pregnant at time o 9 □ Unknown	etal death 3 🗆	Ectopic pregnancy Other <i>(specify)</i>	′		23d. Date Mont	of delivery th Da	ay Year
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Ō Q	aw requ	plete	1-171					24a. Was ar	1 24b. W	ere autopsy	findings available letion of cause of
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Vita	Physicien: rthis certifica	Be	25. Was case referred to medical examiner?			100		ath Check only one			
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on	r Attending P er death. rector: After t by the funera	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)		28c. Injur Wor M 1 🔲	k? Yes 2 □ No	20d. Describe no	w injury occurre	d	
	0 = 5 = 1	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre	et, factory, office		28I. Location (Str City or Town		r or Aural Ad	ou <i>te N</i> umber,
	To the Hospitel within 24 hours a To the Funeral I completely tilled	edical	29a. Certifier Check only one) Certifying Phys	ician: To the best of my ker: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the tine	ne, date and plac pinion, death occ	e, and due to the ca urred at the time, da	use(s) and man	ner as state	d. e cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	wite trialiller stated.		29c. Licens			d. Date signed		
			D Will	alı.		D 172	5192		7/11/0		
	7		30. Name and address of person who cor	mpleted cause of death (It		Print)			7,070	w.	
100			N3 H143, 22 S. ( 31. Date liled (Month, Day, Year)		- 130	Uhmter	2 mn	2,30)			
	Sta Registra	No.	31. Date lifed (Month, Day, Year)	32. Registrar's Sig		a B	Course !				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

Amend item / per fin 88/7/7-24-06 vt

			1 - For State Registrar	State	of Maryla		artment rtificate			nd Mental	Hygier Reg. I	_ L U	06	23113
	Physici /Medi		Decedent's Name (First, Midd Rochelle Vines							2. Date of Month July	1 Death	OK	Year	3. Time of Death 12:00 p-M
	Examir	er	4a. Facility Name (If not institution Gillcrest Hospice				Towso	n	ocation of [		В	4c. County of altimor		
	Funeral Director		5. Social Security Number  242–42–0468  Usual Residence of Decedent	6. Sex 1 ☐ M 2 ☐ F	7. Age (In yrs	78 Yrs.	II Under 1 Months		If Under 24 Hours	Min. (Month	f Birth n, Day, Yea 27, 19		9. Birthp Coun	lace (State or Foreign ttry)
	Maryland f show	ō	10a. State 10b. County MD. NA	1		ity, Town or Lo	ocation						1	0d. Inside City Limits
	with the I	I Director	10e. Street and Number 2725 Walbrook Aveu	me apt. 3		Спріє	10f. Zip (				10g. 0	Citizen of W	hat Coun	itry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiane. Important: if item 27 is marked other than "neturet", or iteme 23a or 28a-1 show any hours or other traumatic event, the Madical Examples must be notified at once.	by Funeral	11. Marital Status  1 Never Married 2 Mai  3 Widowed 4 Divorce	12. Was Dec Armed F ried 1 Tyes	cedent Ever in l orces? 2 - No ive X		Was Decede		panic Origin Mexican, F Specify:	? (Specify Yes of Puerto Rican, etc.		14. Race	, White,	etc.
Maryland 21215-0036	within 72 houisne. Isne. Ithen "neture Ite Medical E	Completed	15. Deceder	nt's Education ost grade completed		16a. Dece (Give life. Housek	dent's Usual kind of work DO NOT use eeping	Occupation done during retired)	on ring most of	f working		Kind of Bus		dustry e Hospital
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, Mary	and 2 should lath and Mer 27 is merke er traumatic		19a. Informant's Name/Relation: Nannie Marie Johnso							imore, Mar			tate, Zip	Code)
Baltimore,	Pages 1 ament of He ant: If iten ury or oth		20a. Method of Disposition 1		State	Place of Dispo cemetery, crer Zion Ce	natory or oth	of er place)	7-1	Date 27-2006		Location - C		wn, State
Balt	permit. Depertrumports any inju		21. Signature of Funeral Service	Jones	>	Wy		eral 1	Home 6:	38 N. Gilm		timore	,MD 21	1217
68760,	Physician and Sphysician and Sphysic	sal Examiner	23a. Part1. Enter the disease, o shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a	(or as a consection as a conse	quence of):	er the mode				ry arrest,			Approximate Interval Between Onset and Death
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sion	Attending Physician: or death. sctor: After this certifically the funeral director, is	Certification:	27. Manner of Death  1 Natural 5 Pendir 2 Accident investi	gation	of Injury oth, Day Year)	28b. Time of Injury	M 280	Mork? 1 ☐ Yes	s 2 No	28d. Descri	be how inj	ury occurred	ı	
N N	To the Hospital or Attending Physician: The i within 24 Hours after death. To the Funeral Director: After this certificate his completaly filled in by the funeral director, page	Certific	3 Suicide 6 Could 4 Homicide determ	nined 289. Place build	e of Injury - At h ing, etc. (Speci	<b>(</b> y)				City or	Town, Sta	te)		Route Number,
	To the Hospital or within 24 hours after To the Funeral Diracompletaly filled in b	edical	29a. Certifier 1 Certifyir (Check only one)	ng Physician: To the Examiner: On the b and man	e best of my knowasis of examination stated.	owledge, death ation and/or inv	occurred at restigation, in	the time, my opini	date and pl ion, death o	ace, and due to to accurred at the time	he cause( ne, date ar	s) and manr nd place, an	er as sta d due to	ted. the cause(s)
		Σ	29b. Signature and title of certifie	ing Ret	2m. 6	no		License nu				ate signed (		
	2		30. Name and address of person	54 G.4	sinc	6701	Print) N- C	ha	iles .	St. Bo	elto	. md	2	<20>
	Sta Registr		31. Date liled (Month, Day, Year)	2006	legistrar's Sign	ature A	2088							

			For State Registrar	State	of Marylar		artment of F	lealth and N <i>Death</i>		giene Reg. No	2006	23	114
n	Physicia	- 41	Decedent's Name (First, Middle Linda	e, Last)	Ann		Wash	ington	2. Date of De. Month	ath 20 Day	2006 Year	3. Time 6:1	of Death
	/Medic Examin		4a. Facility Name (If not institution 4 Glenwood Ro				4b. City, Town, o	r Location of Death		4c. (	County of Death		
÷	Funeral Director		5. Social Security Number 214-96-0256	6. Sex 1 □ M 2√2 F	7. Age ( <i>In yr</i> s. 40	last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bin (Month, Da 2-26-		9. Birthp Cour	lace (State try) MC	or Foreign
	e Maryland a-f ehow	ctor	Usual Residence of Decedent  10a. State  10b. County  Md.	N A		ty, Town or Lo	cation imore				1		City Limits
	th with the 23a or 28	Funeral Director	10e. Street and Number 4 Glenwood Ro	d. Apt.	С		10f. Zip Code 21	221		10g. Citiz	en of What Cour	ntry?	
0000	urs after dea oi', or items	by Funer	11. Marital Status  1 Never Married 2 Marr 3 Widowed 4 Divorced	Armed	ocedent Ever in U Forces? s 2 No Give Dates:	11	Was Decedent of H f Yes, specify Cuba I ☐ Yes 21 No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		4. Race - Amend Black, White, Specify: BL		
N-0171	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: if item 27 is marked other than "naturel", or items 23a or 28a-f show expiriguty or other traumatic event, the Medical Expiriter must be notified at once.	Completed	15. Deceden (Specify only highe: Elementary/Secondary (0-12) 12th grade	st grade completed	d) (1-4or 5+)	(Give	lent's Usual Occup kind of work done DO NOT use retired nemploye	during most of work d)	ang	16b. Kin	nd of Business/Ind	dustry	
and 2	d be filed intal Hygic ed other	Be	17. Father's Name (First, Middle,  Booker	Last)	т.		hington	18. Mother's Nam		Maiden S		h	
Mary	d 2 should th and Me 17 ie mark traumati	L L	19a. Informant's Name/Relations Montyer Wash:		Sister	19b. Mailin	ig Address (Street	and Number or Rui	ral Route Numbe		Town, State, Zip	Code)	17070
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Dailimo	permit. P Departme Importan eny injur		21. Signature of Funeral Service			1	ount Cer Name and Addre arch F.H.		7-06 Baltin 1101	nore,	timore, Md. 2] orth Ave	1206	
9700,	death certificate be executed  Wedical  Water transit  Water trans	dical Examiner	shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Due to	o (or as a consequence o (or a co	quence of):	elllu	ng cu	ncer			Interval B Onset an	
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ion of Vital	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate completely filled in by the funeral director, page	ertification: To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendin investig	Hospital: 1 [ 28a. Dat (Mo	□Inpatient 2 □ e of Injury onth, Day Year)	ER/Outpatien 28b. Time of Injury	28c. Injur Wor	y at		dence 6	Other (Specify occurred	·/)	
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	he Hospi in 24 hour he Funer pletely fill	edical	(Check only 2 Medical one)	Examiner: On the and ma	he best of my kno basis of examina anner stated.	owledge, death ation and/or in:	estigation, in my o	ne, date and place, pinion, death occur	red at the time,	date and p	place, and due to	the cause	(s)
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0	2		30. Name and address of person Tule R. By	who completed ca	use of death (Iter	m 23a) (Type,	Print)	tree & I	Baltin	rore	Marylas	id 2	1231
100	Sta Registr		31. Date filed (Month, Day, Year)	2006	Registrar's Signa	ature And	all!				/		

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amend 1tem 20b per Th 3858 8-4-06 vt

State of Maryland / Department of Health and Mental Hygiene [] [] [] Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Yeer 18 55 BONALD WINDER 07 2006 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner JOHNS HOPKINS BANVIEW MEDICAL CONTEN BALTIMORE If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 DM 2 F 220-56-5780 49 Sep 25, 1956 Md Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Director Md **Baltimore** 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3527 East Fayette Street 21224 U.S.A. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Race - American Indian Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 ☐XNo Specify: Specify. 3 Widowed 4 Divorced Black Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) home improvement handyman 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) ukn Madeline Claxston 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Margaret R. Winder Wife 3527 East Fayette Street Baltimore, Md 21224 20b. Place of Disposition (Name of cometery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 7-31-06 1 Burial 2 Cremation 3 Removal from State **Trinity Cemetery** \* 4 □ Donation 5 □ Other (Specify) Baltimore, Md 21. Signature of Frineral Service License 22. Name and Address of Facility Miller"s Metropolitan Chapel P.C. 1639 North Broadway Baltimore, Maryland 21213 23a. Part1. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediete Cause (Final disease or condition resulting in death) HOUTE Due to (or as a consequence of) Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of) IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? RESPIRATORT 4 Munknown DISTRESS Completed 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 1 ☐ Yes 2 2 No 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 Inpatient examiner Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 @Natural 5 Pending 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one)

The law requires that the death certificate be executed P. 0. Division of Vital Records, or Attending Physician: within 24 hours after death.

To the Funeral Director: A completely filled in by the fu Hospital the

certificate has

After

Box 68760

State Registrar

DHMH 17 Rev 1/2001

**Physician** 

**Funeral** 

Director

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**Physician** 

/Medical

Examiner

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Physician/Medical

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Certification: To

Medical

29b. Signature and

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Pages 1 and 2 should nent of Health and Men

other traumatic event,

Be

The Medical Exactions must be notified at

with the Maryland

filed within 72 hours after death

Baltimore, Maryland 21215-0036

/Medical

JUSTEN

30. Name and aggress of person who completed cause of death (Item 23a) (Type, Print)

title of certifier

M.D

29c. License number

1265-000

29d. Date signed (Month, Day, Year)

Riese Type of Brint in Black Indefible lok ws State of Maryland / Department of Pealth and Mental Hygie

naid Allen vv		1- For State Certifica Registrar	ate of Death	and Menta	F	Reg No. 20(	06 2311	
Physici dical Exam		1. Decedent's Name (First, Middle,Last)  Donald Allen White, Jr.			2. Date of Dea Month July 16, 2	Day Year	3. Time of Death 2218 hrs	
		4a. Facility Name (if not institution, give street and number) 7805 Jay Wick Ave		n, or Location of	Death	4c. County of Dea		
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birth 37 37		1010		Prince Geor		
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town of	or Location	•			10d Inside City Limits	
*	r		ashington				1 Yes 2 XXNo	
Maryla 28a-f. dator	Director	10e. Street and Number	10f, Zip Co		T	10g. Citizen of What Co	•	
ith the Maryland 23a or 28a-f show notified at once.	al Di	7805 Jaywick Ave	42 Mrs Dandari	20744	2/2	United Sta		
Baltimore, MD 21215-0036  pernit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygienic Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral		13. Was Decedent of Park 1 Yes Yes			14 Race - Am White, etc.	erican Indian, Black, Black	
ours af <b>atural</b> ' <u>xamin</u>	d by	15. Decedent's Education (Specify only highest grade completed) 16a. D	Decedent's Usual Occ during most of working	upation (Give kir		16b. Kind of Busines	s/Industry	
5-0036 led within 72 h Hygiene. other than "n	Completed	Elementary/Secondary (0-12) 12 College (1-4 or 5+) Ma	nager		,		Communication	
215-C be filed valued Hyginked oth	Be Co	17. Father's Name (First, Middle, Last)  Donald Allen White		18.Mother's	Vonder Ande Maso	Maiden Surname) <b>n</b>		
To prove the state of the state								
re, MC 1 and 2 sh Health an fitem 27 i		20a. Method of Disposition 20b. Place of	of Disposition (Name of Disposition (Name of Disposition (Name of Disposition)		Date	20c. Location - City		
imore Pages 1 ment of 1 tant: If		4 Donation 5 Other Specify: Lee Cr	ematory Ju				Maryland	
Balt Departi		21. Signature of Fuheral Service Licensee				I Home,Inc inton, MD 2		
Physician	``	Mus X War4 100857 23a. Part I. Enter the disease, or complications that caused the death. Do not		_			Approximate Interval	
/Medical		failure. List only one cause on each line. Immediate Cause (Final disease a. ASphyxia					Between Onset and Death	
		or condition resulting in death)  Due to (or as a consequence of):  Inhalation of exhaust fumes						
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause						
	Examine	(Disease or injury that initiated events resulting in death) Last but to (or as a consequence of):						
ecuted and transi		d	ME O TV	0017 7 /01	a loc mm			
760, icate be executed physician and the burial - transit	fedical	UNPENDED   X AMENDED item#4a-b, pe	enue, 8 perff,	G857, 7/28	8/06 TT	23d. Date of delive	201	
Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be executed within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physician/M	23b. Was decedent pregnant in the past 12 months?  1			regnancy	Month	Day Year	
.O. Bhat the ded by the etached	by Phy	Part II. Other significant conditions contributing to death but not resulting	g in the underlying car	use given in Part		obacco use contribute		
fs, P quires t en signe					1Ye		autopsy findings available	
Division of Vital Records, P.O tal or Attending Physician: The law requires that is after death.  an Director: After this certificate has been signed be led in by the funeral director, page 2 should be detacted.	Completed				auto perfo 1 🗸 Yes	psy prior to prmed? death	completion of cause of	
/ital sician: is certi	Be	25. Was case referred to medical examiner? Hospital: 1 Inpatient 2 ER/Ou	utpatient 3 DOA	Other	Nursing Home 5	Residence 6 🗸 Oth	ner: Scene	
n of V Jing Phy  After th funeral c	n; To	27. Manner of Death 28a. Date of Injury 28b. T	Time of Injury 28c.	Injury at Work?	28d. Describe	how injury occurred		
Sion Attendi death. ctor: /	atio	2 Accident Investigation Jul 16, 2006 2145	5 hrs	Yes 2 V	lo l	V		
Division ospital or Attenchours after death neral Director; y filled in by the	Certification:	3 V Suicide 6 Could not be 4 Homicide 6 Could not be 4 (Specify) Single Family	arm, street, factory, of	ice building, etc.	or Town,		Rural Route Number, City	
Division  To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, dea one) 2 Medical Examiner: On the basis of examination and/or in and manner stated						
F . W . G	Ř	29b. Signature and title of certifier		cense number	<del></del>	29d Date signed (A	fonth, Day, Year)	
		Calrellation	0	o.C.M.E.		July 17, 2006		
OF		Name and address of person who completed cause of death (Item 23a)     Zabiullah Ali, M.D. Assistant Medical Examiner 11	11 Penn Street, I	Baltimore, MI	D 21201			
1 10 8	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature	A 10.					

DHMH 17 Rev 1/2001 OCME 2006 ORIGINAL

			1 - For State Registrar	State of Marylan		artment of I		Mental Hy	giene Reg. No.	006	23117
	Physici	an	1. Decedent's Name (First, Middle, Las			-		2. Date of De Month	ath Day	Year	3. Time of Death
	/Medic		Lillian M	Anche	or_			July	7,	2006	2 45 AM
	Examin		4a. Facility Name (If not institution, give			-	or Location of Dea	ith	4c. C	ounty of Death	,
			University of March.  5. Social Security Number 6. S	ex 7. Age (In yrs. 1		If Under 1 Year	moile If Under 24 Hr.	S R Data of Riv	••	0 8 8 10	lana (State or Famina
H	Funeral Director			□M 2√2F 66	• •	Months Days	Hours Mir		794C	) Vire	place (State or Foreign atry). LN1a
			Usual Residence of Decedent					1.12.1.20	,, , ,	77-6	
	ylanc how		10a. State 10b. County		, Town or Lo					1	0d. Inside City Limits
	e Ma	cto	Maryland Prince (	George's Coll	lege Pa	ark					1 X Yes 2 ☐ No
	h with th	ai Directo	10e. Street and Number 9746 Wichita Aver	nue		10f. Zip Code 207	740		10g. Citize Unit	n of What Cour ced Stat	ntry? tes
036	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. d other then "natural", or itema 23a or 28a-f ehow event, the Modical Examinar must be notified at	by Funeral	11. Marital Status  1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	1	Was Decedent of I f Yes, specify Cub 1 ☐ Yes 2 XNo	Hispanic Origin? ( an, Mexican, Pue Specify:	Specify Yes or No rto Rican, etc.)		. Race - Americ Black, White, pecify:	
Ď	2 ho	ted	15. Decedent's Ed	flucation	16a. Dece	dent's Usual Occup	oation		16b. Kind	of Business/In	dustry
2	thin 7	ed (	(Specify only highest gra	College (1-4or 5+)		kind of work done DO NOT use retire	d) d)	onking		1	
7	od wil	Be Completed	10 '		House	ewife				vn home	
Maryland 21215-0036	8 4 a 8	To Be	17. Father's Name (First, Middle, Last) Arthur	Pultz			18. Mother's Na Bertha	me (First, Middle Maye 1	Maiden Su Mayse	итате)	
, Man	es 1 and 2 should to the library of Health and Ment of Item 27 is marked to the rother traumatic expenses.		19a. Informant's Name/Relationship (7 Maurice Anchor -ht	Гуре, Print) 1sband	19b. Mailir 9746	ng Address <i>(Street</i> Wichita	and Number or P Avenue (	Route Numb College 1	Park,	own, State, Zip Mary Lat	nd 20740
altimore,	To Far Far		20a. Mathod of Disposition  1 DeBurial 2 Cremation 3 C		lace of Dispo	sition (Name of matory or other pla	ce)	Date	20c. Loca	tion - City or To	own, State
Ĕ	Pages ment of ant: If It		4 Donation 5 Other (Specify		rerview	w Cemeter	ry 7/11	L/2006	Wayne	esboro,	/irginia
Ball	permit. Pages Department of Important: If It eny Injury or o		21. Signature of Funeral Serv. Liven	Marchin	Do 122	Name and Address Onald V 400 Powde	Borgwarder Mill I	it Funera Road Beli	al Hon tsvill	ne, PA Le, Mary	land 20705
			23a. Part1. Enter the disease, or comp shock, or beart failure. List only	olications that caused the death one cause on each line.							Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. Large 13 Due to (or as a consequ	ce11	1420	homa				Onset and Death
н	/Medical Examiner		resulting in death)	Due to (or as a consequ	ience of):	)					
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	ed list	Examiner	Sequentially list conditions, if any, leading to intimediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequ	iende otj:						
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28	ficate phys s the	edicai		. d							
XOR	death certificate be executed e attending physicien and ed for use as the burial-transli	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					230	d. Date of delive	erv
ň	death a atte d for	Icia	in the past 12 months? 1 ☐ Yes 2 ☐ No	1□Live birth 2□Fetal 4□Pregnant at time of de		]Ectopic pregnanc ] Other <i>(specify)</i> _	у			Month	Day Year
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Vital Records, P.	8 50	ρ	Part II. Other significant conditions of	ontributing to death but not resu	Ilting in the u	nderlying cause giv	ven in Part I.			-	ne cause of death? ably 4 Unknown
ဝ္ပ	aw require as been si 2 should b	Completed						24a. Was	an 2	24b. Were auto	psy findings available
ř	0 5 6	mo							rmed?	death?	npletion of cause of
<u>a</u>	iiclen: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of De	1 ☐ Yes eath (Check only o		1 🗆 Yes	2(#TNO
>	Physiclen: r this certifica ral director, p	To B	examiner? 1 ☐ Yes 2 ☐ ★6	Hospital: 1 ☐Inpatient 2 ☐ I	ER/Outpatien	t 3□ DOA Ott		Home 5 ☐ Resid		Other (Specify	<i>(</i> )
on of	Afte fune		27. Manner of Death 1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	Wo		28d. Describe I			
5	f or Attendi after death. Director: A I in by the fu	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, str	eet, factory, office		28f. Location () City or Tox	Street and N vn, State)	Number or Rura	l Route Number,
	To the Hospital or Attend within 24 hours after deat To the Funeral Director: completely filled in by the	edical C	29a. Certifier 1 ☐ Certifying Ph (Check only one) 2 ☐ Medical Exam	ysician: To the best of my knowniner: On the basis of examinat	wiedge, death ion and/or inv	occurred at the til	me, date and plac opinion, death occ	e, and due to the urred at the time,	cause(s) an	nd manner as st ace, and due to	ated. the cause(s)
	To the within 2 To the complet	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licens	se number		29d. Date s	signed (Month, i	Dey, Year)
			Ma-m			PIS	548			y7,2	• •
	10		30. Name and address of person who	completed cause of death (Item	23a) (Type	Print)				/ / / ^ ·	
			Richard Fricson	22 501.76 Gres	11 Str	eet! R-	limore	MO )	1201		
	Sta		31. Date filed (Month, Day, Year)	22 South Green 32. Registrar's Signal	42 A	action	16.000				
	Registr	ar	JUL 10 7	2006	5 19	All and					

			1 - For State Registrar	State of Mary	land / Depa <i>Cer</i>	artment of H <i>rtificate of L</i>	lealth and M Death		ne 200	6 2311
Ē	Physici /Medic		Decedent's Name (First, Middle, La: THOMAS	LEON	Δ	SKEW		2. Date of Death Month JULY	ls, 20	3. Time of Death 1:20 F M
	Examir		4a. Facility Name (If not institution, give Saint Joseph				Location of Death	on	4c. County of D	eath ltimore
	Funeral Director		218-30-1380	ex 7. Age (In	yrs. last birthday) 67 Yrs.	If Under 1 Year Months Days	II Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y 11/20/1	9. g 938	Birthplace (State or Foreign Country) Maryland
	hours after death with the Maryland turel', or Itams 23e or 28e-f ehow at Examinar must be notitized at	Funeral Director	Usual Residence of Decedent  10a. State  10b. County  MD. Harf  10e. Street and Number  5163 Norrisvi  11. Marital Status	ord  lle Road  12. Was Decedent Ever	c. City, Town or Lo		Thite Ha	10g		10d. Inside City Limits 1 □ Yes 2 No  Country?  d States mencan Indian.
215-0036	72	þ	1 Never Married 2 Married 3 Widowed 4 Divorced  15. Decedent's Ec (Specify only highest gra	Amed Forces?  1 Myes 2 No If Yes, Give Year or Dates:  ducation de completed)	1958	f Yes, specify Cuba  I Yes 2 No  Jent's Usual Occupa kind of work done of the color	Specify:		Black, W Specify:	White
<b>N</b>	Hygie Ther nt,	Completed	Elementary/Secondary (0-12) 17. Father's Name (First, Middle, Last)	College (1-4or 5+)		ck Driv	er	e (First, Middle, Ma	Autom	obile
ryland	b d la b	To Be		amodie	Askew		Clara	Mar	ie	Marshall
ore, mar	Health Health tem 27 other to		Patricia Jean A  20a. Method of Disposition  1	Askew/ Wif	e 5163 Ob. Place of Dispos cemetery, cren	Norris	ville R	d. Wh	ite Ha.	11, Md.
Baitimore	permit. Pages Department of Important: If I eny Injury or one		4 Donation 5 Other (Specification of Funeral Service Licentification)		22	. Name and Addres	s of Facility Ja		ille, ]	sville, Md Maryland e, P.A.
ъ.	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last	a. RESPIRA  Due to (or as a cor  Due to (or as a cor  Due to (or as a cor	TORY ARI nsequence of): OBSTRUI nsequence of): ASE/EMFI	REST/HYF	POXEMIA			Approximate Interval Between Onset and Death UNKNOWN
O. Box 68/60,	res thet the death certificate be executed igned by the attending physicien and be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	d	Fetal death 3 🗌	Ectopic pregnancy Other (specify)			23d. Date of c	delivery Day Year
ecoras, P	requires thet the een signed by th hould be detache	Ď	Part II. Other significant conditions o	ontributing to death but no	t resulting in the un	derlying cause give	n in Part I.			to the cause of death?  Probably 4 □Unknown
Rec	₹ 0 0	Completed						24a. Was an autopsy performed	1? prior to	autopsy findings available o completion of cause of ?
DIVISION OF VITAL	To the Hospital or Attending Physician: The la within 24 hours effer death. To the Funeral Director; After this centificate has completely filled in by the funeral director, page 2	Certification: To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No  27. Manner of Death  1 ☒ Natural 5 ☐ Pending investigation  3 ☐ Suicide 6 ☐ Could not be determined	28a. Date of Injury (Month, Day Yea	At home, farm, stre	28c. Injury Work M 1 \( \triangle Y	at ? ′es 2 □ No	me 5 Residence 28d. Describe how i	njury occurred	pecify) Rural Route Number,
_	e Hospital 24 hours e Funeral I etely filled	Medical Ce	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the best of my niner: On the basis of exam and manner stated.	knowledge, death mination and/or inv	occurred at the time	e, date and place, a inion, death occurre	and due to the caus and at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
)		Me	29b. Signature and mule of certifier	gu			number 7904	29d.	P/16	ofth, Day, Year)
	Sta Registr		30. Name and address of person who SHILFI AHMED,  31. Date filed (Month, Day, Year)	M. D. 76 Ø 32. Gegistrar's S	(Item 23a) (Type, F	DRIVE.	TOWSON,	MARYLA	ND 2120	214

Funeral

Director

permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or Itema 23a or 28s-1 show eny houry or other traumatic event, tre Medical Evantuar must be rodified at once.

Physician /Medical Examiner

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit

Division of Vital Records, P.O. Box 68760,

Baltimore, Maryland 21215-0036

Sylvia Judd Buch

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

		1- For State of Maryland / E Ragistrar		rtment of He tificate of D		lental Hy	giene Reg. No.	06	23119
Physici /Medic		1. Decedent's Name (First, Middle, Last) Judd Bur	ch			2. Date of De Month	Day	Үөаг 006	3. Time of Death
Examir	er	4a. Facifity Name (If not institution, give street and number)  Doctors Community Hospital		4b. City, Town, or I Lanham	_ocation of Death	/		ty of Death	orge's
Funeral Director		0,5 10 0251		If Under 1 Year Months Days	ff Under 24 Hrs. Hours Min.	8. Date of Bir AMonth, 9	<sup>th</sup> 1921	9. Birthpl NEW	ace (State or Foreign York
a-f show	ctor	Usual Residence of Decedent  10a. State 10b. County 10c. City, Town  Maryland Howard Syke	vn or Loca esvi					10	0d. Inside City Limits 1 ☐ Yes 2 ☐ Yeo
3a or 28	Funeral Director	10e. Street and Number 1250 Heritage Farms Court		10f. Zip Code	21784		10g. Citizen of Uni	What Count ted St	try? ates
al, or Itema 2 Exa⊤inar mu	by	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S. Amed Forces?  1 Yes 2 No ff Yes, Give Year or Dates:	lf `	as Decedent of His Yes, specify Cuban  Yes 2 No	panic Origin? (Spi , Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)		ice - America ack, White, e	
Department of Health and Mential Hygiene.  Department of Health and Mential Hygiene.  Provincent: If them 27 is marked other than "natural, or frems 23s or 28s-1 show eny injury or other traumatic event, the Medical Examinat must be notified at once.	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give ki	ont's Usual Decupat ind of work done du O NOT use retired) aker	ion ring most of work	ing	own hor		ustry
rental Hy rked oth lic event	To Be (	17. Father's Name (First, Middle, Last) William Judd			8. Mother's Name Ella	e (First, Middle		me) Connor	
alth and N 27 is mai er traumai		Preston M. Burch -son	250 1	Address (Street ar Heritage	rarms Co	urt Syl	er, City or Town KESVIII	, State Zip Mar	ÿland21784
yer other			ary, crema	tion (Name of atory or other place) an Cremat	)	oate '2006	20c. Location		<sub>vn, State</sub> Virginia
Departme Importan any injur once.		21. Signature of Service Licensee	DO	Name and Address	of Facility Borgwardt	Funera	al Home	, PA	
ysician Medical		23a. Part1. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of the con	not enter						Tand 20705 Approximate Interval Between Onset and Death  Jews
physician and in the burial-transit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resufting in death) Last  Due to (or as a consequence of the control of	07 81 V	ria e Cana	do Vu	scula	1 Disea	cen	days years
physiciar the buri	dicai								
within 24 fours after death:  To the Funeral Director. After this certificate has been signed by the attending p completely filled in by the funeral director, page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown  1 □ Unknown  23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetaf death 4 □ Pregnant at time of death 9 □ Unknown		ctopic pregnancy Other (specify)				ate of deliver	y Day Year
n signed by uld be deta	ρ	Part II. Other significant conditions contributing to death but not resulting in	n the und	erlying cause given	in Part I.	23e. Did t		tribute to the	cause of death?
ate has bee page 2 sho	Completed					24a. Was autop perfo	rmed?	Were autop: prior to com death? 1 \( \text{Yes} \) 2	sy findings available pletion of cause of
certific rector,	Be	25. Was case referred to medical examiner?		Other	26. Place of Death	(Check only o	ne)		
in. : After this s funeral di	ition: To	27. Manger of Death 28a. Date of Injury 28b. T	Time of Injury	28c. Injury a Work?	t Nursing Hor		dence 6 Oth		
s arren des al Director ad in by th	Certification:	3 Suicide 4 Homicide  6 Could not be determined  28e. Place of fnjury - At home, far building, etc. (Specify)	ırm, stree	t, factory, office	2	28f. Location (5 City or Tox	Street and Numb vn, State)	ber or Rural	Route Number,
De Funera	edical (	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, one to the basis of examination and and manner stated.	id/or inves	stigation, in my opir	nion, death occurre	ed at the time,	date and place,	and due to t	he cause(s)
comp	ğ	29b. Signature and title of certifier  Kakish Managara	MI	29c. License r	2010	8	29d. Date signe	d (Month, D.	ay, Year)
		30. Name and address of person who completed cause of death (Item 23a) (	(Type, Pri	ant For	X /N 5	te 222	Bru	ie m	D MARIE
Sta Registr	16	30. Name and address of person who completed cause of death (Item 23a) (  AKES HOTA 14300 (  31. Date filed (Month, Day, Year) 32. Pagistrar's Signature  JUL 10 2006	Spe	ules .	- ~14,0			1 10	בוויטג עו

DHMH 17 Rev 1/2001

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			1 - For State Registrar		aryland / D	epartme Certifica	ent of H	ealth and Death		giene 0 0 6	23120
	Physici /Medic		1. Decedent's Name (First, Middle, La Sam W.	st) Breche	r				2. Date of Dea Month July	Day 2006	3. Time of Death 5:45PM
H	Examir		4a. Facility Name (If not institution, given Brighton Gard				ity, Town, or Rocky	Location of Dea	th	4c. County of De	
	Funeral Director		Social Security Number 6. 9		e (In yrs. last birti		der 1 Year	If Under 24 Hrs Hours Min		l a B	irthplace (State or Foreign Country)
	ס		Usual Residence of Decedent						DIM TO	, 1721 110	
	Aarylau I show	ō	10a. State 10b. County  Maryland Montge	5m 6 257	10c. City, Town	or Location kville					10d. Inside City Limits 1 X Yes 2 □ No
	r 28a-	Director	10e. Street and Number	Jille Ly	Roc		Zip Code		1	Og. Citizen of What C	
	th with	ai D	5500 Tuckerman	Lane			208	352	<b>U</b> 1	nited Stat	es of America
Maryland 21215-0036	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23a or 28e-f show aumatic event, the Medical Examinational be incilled at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 X Widowed 4 Divorced	12. Was Decedent Armed Forces?	Ever in U.S. No 942 <b>–</b> 1945	1			Specify Yes or No- rto Rican, etc.)		nerican Indian, lite, etc. White
2-0	"natu	letec	15. Decedent's E (Specify only highest gr		16a.	Decedent's U	work done of	turing most of wo	orking	16b. Kind of Busines	s/Industry
2121	filed within Hygiene. other than "	Completed	Elementary/Secondary (0-12)	College (1-4or 5	5+)	Broke		)		Insura	nce
ng	be filed ital Hyg id other	Be C	17. Father's Name (First, Middle, Last	)					me (First, Middle, .		
yla	should to a marked umatic of	To	Abe Brecher  19a. Informant's Name/Relationship	Torre Corton	405	AA. II' A	(2)			ascertaina	•
	and 2 shealth and n 27 is n		Allan Jay Breche							City or Town, State,	
Baltimore,	of Hear		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation ☑		20b. Place of		Vame of		Date	20c. Location - City o	
E E	Pages iment of lant: If its		4 ☐ Donation 5 ☐ Other (Special	<b>'y</b> )		vid Me	m. Gai	ds. 07/			ch, Virginia
Bail	permit. Pages 1 and 2 should be Department of Health and Menta Important: If Item 27 is marked any injury or other traumatic ea		21. Signature of Funeral Service Lice	7500		22. Name	and Addres	<sup>s of Facility</sup> Hi Hampshir	nes Rinal	ldi Funera ilver Spri	1 Home, Inc.
7:	THE		23a. Part1 Enter the disease, or com shock, or heart failure. List only	plications that caused one cause on each li	the death. Do no						Approximate Interval Between
s;	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. Sepsis							Onset and Death 7 Days
ı	Examiner			Due to (or as	a consequence o	f):					7 70
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence o	f):					7 Days
	ecuted and -transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Dunta (or or		4).					
68760,	icate be executed physician and s the burial-transit		l	Due to (or as	a consequence o	1).					
_	tificate ig phys as the	fedical		d							
P.O. Box	The law requires that the death certificate be executed te has been signed by the attending physician and tage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant at 9 □ Unknown	2 Fetal death	3 ☐Ectopic 5 ☐ Other	pregnancy (specify)			23d. Date of de Month	elivery Day Year
o. O	res that igned by be deta	by Pr	Part II. Other significant conditions	contributing to death b	ut not resulting in	the underlyin	g cause give	n in Part I.			to the cause of death?
ord	w require been sig should b		Chronic Lymphoc						1 □ Ye	es 2ÊNo 3⊟P	robably 4 Unknown
Division of Vital Records,		Completed	Chronic Obstruc	tive Lung	Disease		.,		24a. Was a autops perform	nad? death?	utopsy findings available completion of cause of
Vita	ysician: Th	Be	25. Was case referred to medical examiner?	Hospital:			Otho		ath Check only on		
<u></u>	S =	To To	1 ☐ Yes 2 🛣 No 27. Manner of Death	28a. Date of Inju	ry 28b. Ti	me of	28c. Injury Work	4 🖾 Nursing I		ence 6 Other (Spe	ecify)
ion	ath. r: After this	atlor	1 Anatural 5 ☐ Pending 2 ☐ Accident investigation	( <i>Month, D</i> ay	y Year) In	jury M		? ⁄es 2 ☐ No			
DIVIS	al or Atte s after de n Directo	Certification:	3 Suicide 6 Could not b 4 Homicide determined		ury - At home, fari c. (Specify)	m, street, fact	ory, office		28f. Location (St City or Town	reet and Number or R n, State)	lural Route Number,
	To the Hospital or Attendin within 24 hours after death. To the Funeral Director: Att completely filled in by the fun	edical	29a. Certifier Check only one) Certifying Pl	ysician: To the best niner: On the basis of and manner sta	examination and	death occurr /or investigati	ed at the tim on, in my op	e, date and place inion, death occi	e, and due to the ca urred at the time, da	ause(s) and manner a ate and place, and du	s stated. e to the cause(s)
	To th To th compl	Me	29b. Signature and title of certifier	6)	4. 1		29c. License	number	2	9d. Date signed (Mon	th, Day, Year)
	12		> Kama	in K.	Till.	4	D196	09		July 9, 2	2006
			30. Name and address of person who Raman R, Tuli,	MD 108	310 Darne	estown		Suite :	202, Gait	hersburg,	MD 20878
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 10 2	32 Registra	ar's Signature	Joseph	,				

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Ma	aryland	-	artmen rtificate				lental Hy	giene Reg. No	2 U U	5	23	121
	* On		1. Decedent's Name (First, Middle, Las	-					-		2. Date of De	ath Da		ear	3. Time	of Death
	Physici /Medic		WILLIAM JOHN	BATES,	JR.						JULY	6	20		11:	15 P <sup>M</sup>
	Examir	ner	4a. Facility Name (If not institution, give				4b. City,	Town, or	Location (	of Death		40	. County of	Death		
			MONTGOMERY GENERA				-	LNEY		0411-			MONTG			
	Funeral		5. Social Security Number 6. Social Security	X 7. Age	e (In yrs. Ia 72	st birthday) Yrs.	If Under Months	Days	If Under Hours	Min.	8. Date of Bir (Month, Da	th ay, Year)		Coun	try)	e or Foreign
West	Director		Usual Residence of Decedent								Sept.	14 1	.933	Peni	nsylv	ania
	/land		10a. State 10b. County		10c. City,	Town or Lo	cation							10	0d. Inside	City Limits
	Man Fied	ţ	Md. Montgo	mery		Olne:	У								1 🗆 Y	s 2 No
	or 28	lred	10e. Street and Number				10f. Zip	Code				10g. Ci	tizen of Wha	at Coun	try?	
	72 hours after death with the Maryland hnatural, or Iteme 23a or 28e-f ehow alcal Examinar must be notified at	Funeral Director	18016 Archwood Wa	ay			!	208	32			Ur	nited	Sta	tes	
	Iteme	ne	11. Marital Status	12. Was Decedent I Armed Forces?	105		Was Deced	lent of Hi	spanic Ori n, Mexicar	igin? (Spe	ecify Yes or No Rican, etc.)	o-	14. Race - Black,			
36	s afte	by F	1 ☐ Never Married 2X Married 3 ☐ Widowed 4 ☐ Divorced	1 X Yes 2 □ N If Yes, Give Year or Dates:	₀ 195 195	3-	1 Yes 2	/	Specify:				Specify:		hite	
21215-0036	hou	edk	15. Decedent's Ed				dent's Usua	I Occupa	ation			16b K	and of Busin			
215	7 oir	Completed	(Specify only highest grade Elementary/Secondary (0-12)	de completed) College (1-4or 5		(Give	kind of wor DO NOT us	k done d	lurina mos	t of worki	ng	100.10	and or bush	1933/1110	10311y	
21,	d within giene. er than "	E O	12	O	7	Ow	ner						Chemi	ca1	Comp	any
P	be filed tal Hygid d other event, I	Be (	17. Father's Name (First, Middle, Last) William John Ba	tos Cm							(First, Middle		Sumame)			
yla	should be ind Mental marked o	၉		ites, Sr.						l1en	Lidd					
Maryland	2 g m m		19a. Informant's Name/Relationship (7		i						I Route Numb				Code)	
	1 and Health em 27 ther tr		Faith W. Bates / 20a. Method of Disposition	wiie	20h Pla		6 Arc				Olney,		208		Ctot-	
Baltimore,	permit. Pages Department of the Important: if its any injury or of		1 ☐ Burial 2 ☐ Cremation 3 ☐			nce of Dispo metery, cren			1			200. Li	ocation - Cit	yorro	wn, State	
돌	arime prient		4 ☐ Donation 5 ☐ Other (Specify  21. Signature of Funeral Service Licen:		Met	ropol	itan .Name and			7/8/	'06	Ale	xandr	ia,	Va.	
Ba	Deparent Dep		Merriel &	Barl	le.		Muri	e1 H	. Baı	rber	Funera	1 но	me			
	pair to be		23a. Part1. Enter the disease, or comp	lications that caused	the death.	Do not ente	P. O				Layton:		ie, m	a. 2	20882 Approxim	ate
J	Physician		shock, or heart failure. List only of				20		2,0	200	0				Interval B Onset an	
4	/Medical		disease or condition resulting in death)	aOCC			1 Per	4	CM 2	eu s	P				104	(>
	Examiner		Sequendarly list conditions	cere	1000	ASCIL	Cea	PN	int						140	tays.
	pe vit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a conseque	ence of):										
	and al-tran	хап	that initiated events resulting in death) Last	c. Due to (or as a	a consegue	ince of):								-		
8760,	death certificate be executed eattending physicien and dor use es the burial-transit	llcal E		,		,										
.89	ificate g phy es the	edic		u.										1		
Box	eath certific attending pl	M/U	230. Was decedent pregnant	23c. If yes, outcome			Ectopic pre						23d. Date o	f deliver	у	
	ed for	sicle	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at			Other (spe						Month	1	Day	Year
P.0	that the de ed by the a detached i	Physician/Med	9 Unknown													
S,	8 7 9	by	Part II. Other significant conditions co	ntributing to death bu	it not result	ing in the ur	ideriying ca	iuse give	n⊪n Part≀.				use contribu			
Ö	w require been signal	etec														
Vital Records,	0 - 0	ompleted									24a. Was autop		24b. Wer	r to com	sy finding opletion of	s available cause of
<u>ra</u>	icien: Th certificete rector, pag	e Co	25. Was case referred to medical						00 81	-1.5	1 ☐ Yes	2 - No			2□ No	
>		0 8	examiner?	Hospital:	nt 2 🗆 El	R/Outpatien	3 DO	Othe	-		Check only one 5 Residence		6 DOther /	Spanific	1	
οl	ding Phys	n: T	27. Manner of Death	28a. Date of Injur (Month, Day	y 2	8b. Time of		c. Injury Work			8d. Describe			opecity,	/	
Siol		atlo	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	(	, 64.7	,,	М		es 2 🗆 i	No						
Division	or Att	ertification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju building, etc	iry - At hom c. (Specify)	ie, farm, stre	et, factory,	office		2	8f. Location (5 City or Tox		d Number o	r Rural	Route Nu	mber,
	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	O	29a. Certifier 1 Certifying Phy	nining. To the best of	of many land and											
	Hoe 24 hc	dical	(Check only 2 Medical Exami	sician: To the best oner. On the basis of and manner sta	examinatio	edge, death n and/or inv	estigation,	in my op	e, date and inion, deal	d place, a th occurre	ed at the time,	cause(s) date and	and manne place, and	r as sta due to	ited. the cause	(s)
	To the Vithin 2. To the Complet	Me	29b. Signature and title of certifier	10	1		29c.	License	number			29d. Dat	te signed (N	fonth, D	ay, Year)	
	2+1		Korea Ki	ull	71	7100	2   5	000	757	03	2	Joh	1 7,	20	06	
	0'		30. Name and address of person who c	ompleted cause of de	eath (Item 2	23a) (Type, I	Print)		1.9	3111	Prince					
			Greg Kum	Kunian		M. I	>.			ney,		208	_	- /		
	Sta Registr		31. Date filed (Month, Day, Year) 1 0 20	32 Aegistra	r's Signatu	a second	age!									

State of Maryland / Department of Health and Mental Hygiene) 1 - State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** 2006 8:25 P M ANNA BALDWIN Ju1v KATHERN /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Frederick 5042 Shookstown Road Frederick If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** Days Hours 1 M 2 TF Yrs April 29,1921 Pennsylvania 85 Director 200-05-9559 Usual Residence of Decedent 10d. Inside City Limits 10b. County 10c. City. Town or Location 10a. State 28a-f show directional beneatified at 1 ☐ Yes 2 ☑ No Frederick Frederick Maryland Director 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code , or items 23a or States United 21702 5042 Shookstown Road death Funeral 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White the Medical Exp. þ 3 ☐Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene important; if item 27 is marked other than any injury or other treumatic avent Elementary/Secondary (0-12) College (1-4or 5+) Home-maker own home 11 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Cora Johnson Kusinsky John 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2513 Shelley Circle, #3D/ Frederick, MD Faith A. Carpenter /daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State Resthaven Mem.Garden 07/11/2006 Frederick, Maryland 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Stauffer Funeral Homes, P.A. 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or beart failure. List only one cause on each line. 1621 Opossumtown Pike/ Frederick, MD 21702 Approximate Interval Between Onset and Death Immediate Gause (Final disease or condition resulting in death) Peritorias 9 **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine The law requires that the death certificate be executed the burial-transit and Due to (or as a consequence of) Records, P.O. Box 68760 attending physician Physician/Medical use as t IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months?
1 Yes 2 No detached for 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ğ 1 Tes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed2 Yes 2 No 2 No 1 Yes t TYes Division of Vital To the Hospital or Attending Physician: within 24 hours after death.

To the Funaral Director: After this certifica completely filled in by the funeral director. 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 ☐ Nursing Home 5 🌠 Residence 6 ☐ Other (Specify) 1□Yes 2∃No ۲ 1 Inpatient 2 ER/Outpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 1 Natural 28b. Time of 28c, Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 19 Cartifying Physician: To the best of my knowledge, death occurred at the lime, date and place, and due to the dausers) and manner as stated 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Cis 33-106 D16939 10 70 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Behre

Michael Behre Michael Behre / 300 S. Church St./Middletown, MD 21769 egistrar's Signature 31. Date filed (Month, Day, Year) 1 2006 32. State Registrar

			1 = State Amend Item	State of Maryla 24a per ver	nd / Depa b <b>. ,G85</b> 7,	artment of I	lealth and <b>Ghb</b>	d Mental Hyg	iene2 () ()   og. No.	6 23123
			1. Decedent's Name (First, Middle, Last)					2. Date of Deat Month	h	3. Time of Death
	Physici /Medio		Larry D. Burnett					July	13, 2006	
	Examin		4a. Facility Name (If not institution, give s				or Location of De	eath	4c. County of De	
			12001 McKinley Dri  5. Social Security Number 6. Sex		s. last birthday)	Hancock		Irs. 8 Date of Birth	Washing	
ji.	Funeral Director			M 2□ F	57 <sup>Yrs.</sup>	Months Days		Irs. 8. Date of Birth (Month, Day, November	Year) 10.1948	linthplace (State or Foreign Country) MD
	ס		Usual Residence of Decedent					THO CLUSTED	20,2710	
	arylar show	-	10a. State 10b. County	10c. 0	City, Town or Lo	cation				10d. Inside City Limits 1 XYes 2 ☐ No
	28a-f	Director	MD Washingto	n Ha	ncock	10f. Zip Code		1.	0g. Citizen of What	
	with with	ä	189 East Main Stre	ot		21750		'	USA	Country
	death ms 2;	era		2. Was Decedent Ever in	U.S. 13.	Was Decedent of	Hispanic Origin?	(Specify Yes or No-	14. Race - Ar	nerican Indian,
9	or its	Fu	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🛱 No If Yes, Give	1	f Yes, specify Cut 1 □ Yes 2 🕅 No		erto Hican, etc.)	Black, W	
8	ural',	d by	3 ☐ Widowed 4 X Divorced	Year or Dates:						hite
15	filed within 72 hours after death with the Maryland Hygiene. ther than "natural", or Itams 23e or 28e-f show that the Medical Esaninar must be codified at	Completed by Funeral	15. Decedent's Educ (Specify only highest grade		(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of a	vorking	16b. Kind of Busines	ss/Industry
212	iene.	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		Owner	-,		Restaurar	nt
פ	al Hyg other	Be C	17. Father's Name (First, Middle, Last)				18. Mother's N	lame (First, Middle, M	Maiden Sumame)	
ylaı	Menta Menta arked	ToE	Charles Roger Bur	nett			Virg	inia Bohre	r	
Maryland 21215-0036	12 short and 1 ls m		19a. Informant's Name/Relationship (Typ			-		Rural Route Number,		
e,	1 and Health		Zach L. Burnett/So 20a. Method of Disposition		Place of Dispo	sition (Name of		Hancock,	ND. 21/50 20c. Location - City	
nor	ages ant of it: If it y or o		1 XBurial 2 ☐ Cremation 3 ☐ Re 1 4 ☐ Derration 5 ☐ Other (Specify)	emoval from State	cemetery, crer	natory or other pla Cemeter			,	annery, PA
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-1 show styl righty or other traumatic event, It a Macical Examinating Interchial be rediffied at once.		21. Signature of Funeral Service License	5		. Name and Addre			t Main St	······································
ä	Depar Impo sny ir		A CH	Len	_ G	rove Fun	eral Hon			MD 21750-0368
-			23a. Part1. Enter the disease, or complice shock, or heart failure. List only on	e cause on each line.	ath. Do not ent					Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Liver Fai	lure					Onset and Death
À	/Medical Examiner		resulting in death)	Due to (or as a conse						
		ē	Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	equence of):		<del></del>			
	uted d ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events							
o,	an an irial-tr	Exa	resulting in death) Last	Due to (or as a conse	equence of):					
8760,	icate be executed physician and s the burial-transit	dlcai	d.							
9	entific ding p	/Mec	IF FEMALE:	Bc. If yes, outcome of preg	nancy.					
Вох	that the death certified by the attending detached for use as	Physician/Me	in the past 12 months?	1 Live birth 2 ☐ Fe 4 ☐ Pregnant at time of	tal death 3	Ectopic pregnand Other (specify) _	у		23d. Date of d Month	elivery Day Year
o.	the d y the ached	ysi	1 Yes 2 No 9 Unknown	9☐ Unknown		, oo. (apoon)/ _				
٣.	The law requires that the death certifi ate has been signed by the attending age 2 should be detached for use as	by PI	Part II. Other significant conditions conf	tributing to death but not re	sulting in the u	nderlying cause gr	ven in Part I.	23e. Did tob	acco use contribute	to the cause of death?
ord	v require been sig should b	ted t						1 □ Ye	s 2 No 3	Probably 4 Munknown
Vital Records,	e law r has be je 2 sh	Completed						24a. Was ar autops	y prior t	autopsy findings available o completion of cause of
<u>س</u>	(0 ==							perform 1 ☐ Yes 2	ned? death'	? es 2 \( \text{No} \)
Ĭ.	Physician: The this certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:	7500	-0.00	nar	Death (Check only one	ikuk	of Son
of	Phys er this eral di	7: To	1 Yes 2 No	28a. Date of Injury	28b. Time of	28c. Inju	ry at	Home 5 Reside		pecify)
ion	Attending in death.  ector: After by the funer	atio	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	M 1	rk? ]Yes 2 ∐No			
Division	r Attendi er death rector: A	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At building, etc. (Spec		eet, factory, office		28f. Location (Str City or Town	reet and Number or . , State)	Rural Route Number,
	ital o irs aft ral Di		V	,						
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	edical	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin	ician: To the best of my killer: On the basis of examinand manner stated.	nowledge, death nation and/or inv	occurred at the tivestigation, in my	me, date and pla opinion, death o	ace, and due to the ca courred at the time, da	use(s) and manner ate and place, and d	as stated. ue to the cause(s)
	o tha o the omple	Mec	29b. Signature and title of certifier	and manner stated.		29c. Licen	se number	29	3d. Date signed (Mo	nth, Day, Year)
)	F ≥ F ŏ		Matt.	Hahn M.D	1	056	048		July 14:	2006
			30. Name and address of person who con		эт 23а) (Турө,			1.5		-
	c=		Matthew Hahn, 130	West High S		tancock	Vary land	21750		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Sign	nature	,				

		4	For State Ragistrar	State of	of Maryla		artment of H rtificate of L			jiene leg. No.	06	231	24
			1. Decedent's Name (First, Middle	, Last)					2. Date of Dea Month	th Day	Year	3. Time of	Death
	Physicia Medic		KAM HON CHEUNG						JULY	1	2006	3:15	РМ
	Examin	er	4a. Facility Name (If not institution	give street and nu	ımber)		4b. City, Town, or	Location of Dea	th	4c. Cour	nty of Deeth		
		•	MANOR CARE OF SI	VER SPRING		rs. last birthday)	SILVER	SPRING If Under 24 Hrs	8. Date of Birth		NTGOME		r Fomian
	uneral irector		5. Social Security Number 579-70-9459	1 M 2 □ F	7. Age (117)		Months Days	Hours Min	. (Month, Day	, Year)	Coul		T POI BIGIT
	Hector		Usual Residence of Decedent						JANUARY 23	1929	CHI	VA.	
nylano	show		10a. State 10b. County		10c.	City, Town or Lo	cation				1	I0d. Inside Ci	
в Ма	Se-f s	cto	MARYLAND PRINCE	GEORGES			TEMPLE HI	LLS				1 🗆 Yes	2 A NO
ith th	De no	Director	10e. Street and Number				10f. Zip Code		1	10g. Citizen o	of What Cou	ntry?	
aath v	s 23s	iai	6807 GENEVA LANE	12 Was Doo	edent Ever i	0116 12 1	Was Decedent of Hi	20748	Engelby Vos or No-	U.S.	A. ace - Americ	can Indian	
be filed within 72 hours after death with the Maryland	Copputing or regarding and whenter hygiens are the more state of the s	Funeral	11. Marital Status 1 ☐ Never Married 2 ☒ Marri	Armed F	orces? 2 XNo	1	f Yes, specify Cuba	n, Mexican, Puer	to Rican, etc.)		lack, White,	etc.	
hours	uraľ,	d by	3 ☐ Widowed 4 ☐ Divorced	Year or I							AS	IAN	
n 72	"nat	Completed	15. Decedent (Specify only highes	t grade completed,		(Give	dent's Usual Occupa kind of work done o DO NOT use retired	luring most of wo	orking	16b. Kind of	Business/in	austry	
with	than	Eo	Elementary/Secondary (0-12) 5	College	(1-4or 5+)		D SERVICE			SELF			
De fiite	othe vant.	Be C	17. Father's Name (First, Middle,	ast) UNKN				18. Mother's Na	me (First, Middle,	Maiden Sum	ame) UNKN	I	
should b	arked	To E				-							
2 sho	Is m		19a. Informant's Name/Relations				ng Address (Street a					·	
and and	m 27		METIN CHEUNG - 1	DAUGHTER	20	b. Place of Dispo	LOCUST TRE	E LAND, A	1	VIRGINI 20c. Location			
ages .	= 50		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation		State	cemetery, crei	natory or other place				,		
j.	orteni injury		* 4 □ Donation 5 □ Other (S <sub>i</sub> 21. Signature of Funeral Service	iennen			INGTON CEME	s of Facility			I, MARY		
	e e		> Muelin T	Lleber	<i>y</i>	1	1800 NEW HA		HINES-RINAL VENUE, SILV				0904
			23a. Part1. Enter the disease, or shock, or heart failure. List	only one cause on	each line.					est,		Approximate Interval Bette Onset and I	ween
	/sician ledical		Immediate Cause (Final disease or condition resulting in death)	a C	ardi	O-Res	biratory	1 911	rest				120
	aminer		,	Due to	(or as a con	sequen <i>ce</i> of):	ular	dice	3.66				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		(or as a con		4 (04)	4/3(4	7				
cuted	ransit	Examin	that initiated events	c					_				
9 8x8	ian ar urial-t	i Ex	resulting in death) Last	Due to	(or as a con	sequence of):							
cate be executed	physician and the burial-transit	dicai		d									
Sertific	ed by the attending p detached for use as	/Me	IF FEMALE:	23c. If yes, or	utcome of pre	egnancy				234 [	Date of delive	30/	
leath o	atten 1 for u	Physician/Me	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 Live	birth 2 Finant at time	etal death 3	Ectopic pregnancy Other (specify)				Month	-	/ear
j e	by the achec	hysi	9 Unknown	9□ Unkı	nown								
s tha	s been signed by the should be detach	by P	Part II. Other significant condition	ns contributing to	death but not	resulting in the u	nderlying cause give	en in Part I.		. /		ne cause of d	
require	sen si		MS of C	VA, es	Cepn	aropa	thy k	neumo	ng 10 Y	es 2 1 No	3 Prob	ably 4 🗆	Inknown
a w	m (V	Completed	sepsis	UTI	HT	w di	ment	ra	24a. Was a autops perfore	SV	prior to co death?	psy findings a mpletion of ca	available ause of
T He	s certificate has b lirector, page 2 s								1 □ Yes	2 No		2 No	
siciar	certif	o Be	25. Was case referred to medical examiner?	Hospital:	Na-sti-st 1	Ω FD/0	Othe	1/	ath (Check only or		Wh (0)		
2 g	ar this aral di	H	27. Man er of Death	28a. Date	of Injury	2 ER/Outpatier 28b. Time o		at Nursing	28d. Describe h	ence 6 🗆 C ow injury occ		у)	
nging 4	ream. tor: After this certificate ha the funeral director, page	ation	1, Natural 5 ☐ Pendin 2 ☐ Accident investig	9	nth, Day Yea	r) Injury		res 2 □ No					
r Atta	iracto iracto	Certification:	3 ☐ Suicide 6 ☐ Could of determ	200. Plac	e of Injury - A	At home, farm, str	eet, factory, office		28f. Location (S. City or Town		nber or Rura	I Route Num	ber,
ا ق	ral Di												
To the Hospitel Or Attanding Physician: The law requires that the death certification.	within 24 hours after death.  To tha Funeral Diractor: A completely filled in by the fu	edical	29a. Certifier 1 Certifyin (Check only 2 Medical one)	- AOITHITION, OIT (IIIO	ie best of my basis of exam nner stated.	knowledge, deat nination and/or in	n occurred at the tim vestigation, in my op	e, date and plac pinion, death occ	e, and due to the curred at the time, d	ause(s) and i late and place	manner as s e, and due to	tated. the cause(s	)
To th	To th comp	Me	29b. Signature and title of certifie	(	1	110	29c. License	number	- 0 2	9d. Date sign	ned (Month,	Day, Year)	
7			· (//mg	Lelle	< /	7.10	200	100 30	02	1-0.	-06	/_	
			30. Name and address of person	who completed cau	of death	23a) (Type)	DOI DIE	e A.D.	1208	52	carr	per	MAR
1	Sta Registr		31. Date filed (Month, Day, Year)	2006	Registrar's Si	ignature dos	de						•

		•	For State Registrar	State of Ma	aryland / Depa <i>Ce</i>	artment of F		Mental Hy	giene (	06	23125
	Physicia	an	1. Decedent's Name (First, Middle, Last,	1				2. Date of De Month	Day	Year /	3. Time of Death
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, o	r Location of Dea	ith	4c. Cou	nty of Death	_10_A
Т	Examin	er	HCR Manor Care			Silver	Spring		М	lontgome	erv
	Funeral		Social Security Number 6. Second Second Security Number 8. Second Security Number 8. Second Security Number 8. Second Security Number 8. Second Second Security Number 8. Second Sec	x 7. Age	e (in yrs. last birthday)	If Under 1 Year Months Days			th V. Year	9. Birthpla	ace (State or Foreign
	Director		101 10 1250	] M 2[XF	77 Yrs.	,		001. 10	7, 1928		India
	and land		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10	0d. Inside City Limits
	Mary I sh	Į.	Maryland Montgome	ery	Silver S	Spring					1 ▼Yes 2 No
	72 hours after death with the Maryland "neturel", or Items 23e or 28a-f show rdical Examiner must be notified at	i Director	10e. Street and Number 11313 Classical I	Lane	1	10f. Zip Code 209	01		•	of What Count	of America
	er death Items 2: ner mus	Funerai	11. Marital Status 1 □ Never Married 2 □ Married	12. Was Decedent : Armed Forces?		Was Decedent of H If Yes, specify Cubi	lispanic Origin? ( an, Mexican, Pue	Specify Yes or Norto Rican, etc.)		Race - America Black, White, e	
9003	hours aft urel', or	þ	3 Widowed 4 □ Divorced	1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		1 ☐ Yes 2 ☑ No	Specify:			_	n Indian
Maryland 21215-0036	- 3	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5	(Give	kind of work done DO NOT use retire	during most of we	orking	165. Killa oi	f Business/Indu	ustry
7			17. Father's Name (First, Middle, Last)	2	Hor	nemaker	18. Mother's Na	ame (First, Middle		Home	
yland	D = D •	To Be	Kirpa Ram Mitro	)			Ram Re	khy			
Jan	W = - 3		19a. Informant's Name/Relationship (T)			ng Address (Street					
e,	1 and Health Bm 27 ther t		Vijay Kushawaha - 20a. Method of Disposition	· Daugntei	20b. Place of Dispo	3 Classic		Date	1 0	on - City or Tow	
Jou	Ti it of		1 Burial 2 Cremation 3 F		Ft. Linco	matory or other pla	tory 07	//07/06			Maryland
Baltimore,	permit. Pages 1 and 2 Department of Health a Importent: If item 27 is eny injury or other tra		21. Signatura 1 Fune 1 3 Type Lines								Home, Inc.
	40360		23a. Part J. Enter the disease, or comp	lications that caused							g, MD 20904 Approximate
Ь	Priysician	, i	shock, or heart failure. List only o Immediate Cause (Final disease or condition	ne cause on each li	<sub>ne.</sub> ent Aspirat						Interval Between Onset and Death 1 Month
-4	/Medical Examiner		resulting in death)	a	a consequence of):						
	Cxammer	<u></u>		b. Due to (or as	a consequence of):						
	nsit	Examiner	if any, leading to immediate  Enter Undert in Cause (Disease or injury	500 10 (0. 43	a consequence on.						
o,	be executed sicien and burial-transit		that initiated events resulting in death) Last	Due to (or as	a consequence of):						
8760,	ate be thysicil	dicai		d							
O. Box 6	ath certific attending p for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ⊠ No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant at 9□Unknown	2 Fetal death 3	Ectopic pregnance Other (specify)	ivet	aplica	61e_23d.	Date of deliver Month [	ry Day Year
<u>α</u>	that the de led by the a detached		Part II. Other significant conditions co	ntributing to death b	out not resulting in the u	ınderlying cause gıv	ven in Part I.	23e. Did	tobacco use c	ontribute to the	e cause of death?
ords,	w requires that been signed should be de	ted by	Cardiomyopathy					10	Yes 25 CNo	3 ☐ Proba	ably 4 <sup>*</sup> □Unknown
Record	The law i ate has bu page 2 sh	Completed	Diabetes					24a. Was auto perf 1 🗆 Yes		prior to com death?	osy findings available inpletion of cause of
Vital		Be C	Hypertension 25. Was case referred to medical examiner?				26. Place of De	eath (Check only	Α		X
of V	d is	To	1 ☐ Yes 2Ã No	Hospital: 1 ☐ Inpatie		nt 3 DOA		Home 5 ☐ Res			)
	ding P. h. After t funera	ion:	27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of Inju (Month, Da	ury 28b. Time o ny Year) Injury	Wo	ryat rk? ]Yes 2 □ No	28d. Describe	how injury occ	curred	
Division	or Attending after death. Director: After in by the fune	licat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of In	jury - At home, farm, si		163 2 110			ımber or Rural	Route Number,
Div	after after Direct of in by	Certification:	4 ☐ Homicide determined	building, et	tc. (Specify)	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		City or To	wn, State)		
	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Medical C			of my knowledge, dea of examination and/or in ated.						
	To the within 2 To the complet	Me	29b. Signature and time of certifier	0 1		29c. Licens	se number		29d. Date sig	gned (Month, D	Day, Year)
	1		> Atu	Li		DI	9600	7.	July	7, 200	36
	6		30. Name and address of person who o	ompleted cause of c	death (Item 23a) (Type	Print) RA	MAN 2 GAI	RIT	ull:	^	0.000
			10810 DAKNES 31. Date filed (Month, Day, Year)	COWN 1	1200d S	ule 20	2 GAI	THEPS	BURC	2. M1)	20818
	Sta Regist		JUL 10	2006	we & by	carle					

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Donald M. Cooper

		1- For State Registrar	Ce	rtificate of D	eath	.,,,,,	Reg No	200	6 231
Physic		Decedent's Name (First, Middle, La	•			2 Date of Month		Year	3 Time of Death
Medical Exam	ıner	Donald Miles C		Tac.		June 3	10, 2006		0930 hrs
		4a Facility Name (if not institution, g Holy Cross Hospital	ive street and number)		City, Town, or Location ilver Spring	of Death		ounty of Death ntgomery	1
Funeral		5. Social Security Number 6	Sex 7. Age (In yrs. I				of Birth (MM/DD/		rthplace (State or
Director		208-36-1185	X M 2 F 59	Yrs	Months Days Hou	rs Min. 11	/28/1940	6	<sup>gn</sup> Pennsylvar
ашу	i	Usual Residence of Decedent  10a State 10b, County	10c City	Town or Location					Labining
* .									10d Inside City Limits 1 X Yes 2 No
Aaryland 28a-f show 1 at once.	tor	Md. Montgo	mery S	ilver Spr	ing f, Zip Code		Table 10		
e Mar or 28:	Director		1. D - 1		•			of What Coul	ntry?
vith the s 23a		1801 Grace Churc	12. Was Decedent Ever in U.	S 13 Was Do	20910 cedent of Hispanic Or	rain? / Specify Ver		S.A.	ican Indian, Black,
15-0036  filed within 72 hours after death with the Maryland Hygiene of other than "natural", or items 23a or 28a-fate the Medical Examiner must be notified at once	Funeral	1 Never Married 2 X Marrie	d Armed Forces?	If Yes, s	pecify Cuban, Mexica	n, Puerto Rican, etc.		White, etc.	can Indian, Black,
ifter d II", or		3 Widowed 4 Divorce	1 Yes 2 X No	1 Yes	2 X No specify	<i>/:</i>	Spe	cify Wh	ite
0036 within 72 hours afte iene ier than "natural", Medical Examiner	d by	15. Decedent's Education (Specify	only highest grade completed)		sual Occupation (Give			of Business/I	
6 172 h an "n cal Ey	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)		f working life. DO NO				
003 within iene er tha	μď		5+	Profes	sor of Eng	lish	Howan	rd Uni	versity
MD 21215-0036 of 2 should be filed within 7 than and Memal Hyggiene in 27 is marked other than anmatic event, the Medica		17 Father's Name (First, Middle, Las	,			er's Name (First, Midd		,	
nore, MD 2121 ages I and 2 should be fi nt of Health and Wental t: If item 27 is marked other transmatic event,	To Be	Donald C. Coope  19a Informant's Name/Relationship	Type Print \	19h Mailing Ade	Rut dress (Street and Nu	h C. Will	enbecke	r	
MD 2 nd 2 shou alth and " m 27 is r aumatic	-	Mari Howard-Coo			ace Church				
		20a Method of Disposition	<u> </u>	Place of Disposition		Date Date		tion - City or	
Baltimore, permit Pages I at Department of Hee Important: If ite		1 X Burial 2 Cremation 3	Tremoval from otate	crematory or other p	*	July 5,		,	
Baltimo permit Page Department Important:		4 Donation 5 Other Specif 21. Signature of Juneral Service Lice		and View		July 5, 2006	Alle	ntown,	Pa.
Ba Ba Depa					and Address of Facilit				20007
Physician		23a Part I Enter the disease, or com	plications that caused the death.	Do not enter the m	Wisconsin	AVE., N.	W. Wash	D.C.	20007 Approximate Interval
/Medical		failure. List only one cause on e	each line. <sub>a</sub> Drowning with complica			,			Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	Due to (or as a consequence of						
		Sequentially list conditions,							
	iner	if any, leading to immediate cause Enter Underlying Cause	Due to (or as a consequence of	f):					
+	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of	f):					
cuted			l						
760, cate be executed physician and he burial - transit	ig	UNPENDED	AMENDED						
8760, ifficate be executed ag physician and is the burial - transi		IF FEMALE: 23b. Was decedent pregnant in the	23c. If yes, outcome of pregr				23d. Da	te of delivery	
Box 687  e death certific  the attending p	ian	past 12 months?	1 Live birth 4 Pregnant at time of dea	ath =	eath 3 Ectopi	c pregnancy	Mon	th D	ay Year
Box death he atte	Physicia	1 Yes 2 No 9 Unknow	n 9 Unknown	5 Other	Specify)				
<b>→</b> = 50		Part II. Other significant conditions	contributing to death but not re	sulting in the under	lying cause given in Pa	art I. 23e. D	d tobacco use c	ontribute to t	he cause of death?
9 9 9	d b	Hypertensive atheroscle	otic cardiovascular disea	ase		1 🗌	Yes 2 🗸 No	3 Prob	ably 4 Unknown
Records, The law requir	Completed					24a W			opsy findings available
Vital Recor. hysician: The law r. this certificate has b.	티		-			pe	rtopsy	death?	ompletion of cause of
	Ö	25 Was case referred to medical			26.Place of Death		es 2 V No	1 Yes	s 2 No
of Vital g Physician: frer this certi	o B	examiner? 1 ✓ Yes 2 No	Hospital 1 Inpatient 2	ER/Outpatient 3	DOA Other4	Nursing Home 5	Residence	6 Other:	
Division of V  Division of V  To the Hospital or Attending Physwithin 24 hours after death  To the Functoral Directora: After this completely filled in by the functal of	-	27. Manner of Death	28a. Date of Injury	28b Time of Injury	28c. Injury at Work	c? 28d. Descri	be how injury oc		
on endir ath pr: A	Ęį	1 Natural 5 Pending	FOUND: Day, Year) Jun 29, 2006	FOUND: APPRO	¼. 1 Yes 2 ✔	No Subject d	rowned		
Division Division tal or Attendi rs after death al Director:	ertification:	2 Accident Investigat 3 Suicide 6 Could not	28e Place of Injury - At ho		tory, office building, et	tc. 28f. Locatio	n (Street and Nu	umber or Run	al Route Number, City
Division  Division  To the Hospital or Attention 24 hours after death To the Funeral Director:	erti	4 Homicide determine		pool		10012 Ga	n, State) Irdiner Aven	ue, Silver	Spring, Md.
Di Di 24 hours a Funeral I	aC	29a Certifier 1 Certifying Physic	ian; To the best of my knowledg	e, death occurred a	t the time, date and pla	ace, and due to the c	ause(s) and mar	nner as starte	ed .
To the Howithin 24 h To the Fun Completely	Medical	one) 2 Medical Examine	On the basis of examination an and manner stated.	nd/or investigation, i	n my opinion, death oc	curred at the time, da	ate and place, a	nd due to the	cause(s)
Δ ⊢ ≤ <del>-</del> 5	ž	29b. Signature and title of certifier			29c. License number		29d. Date s	signed (Mont	h, Day, Year)
12		- // /	1		O.C.M.E.		July 1, 2	2006	
		30. Name and address of person who	completed cause of death (Item	23a)					
		Mary G. Ripple MD. De	puty Chief Medical Exam		nn Street, Baltim	ore, MD 21201			
		31 Date filed (Month: Day:Year)	32. Régistrar's Signatur	y food	2				
Regis	rar	JUL UT	ZUUG BERREIS I	J. Johnson					

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 0 0 6 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 3. Time of Death Year **Physician** OCIANO. 08 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Berlin Mu ItHICATIC Worker ter General Huspital If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Days Hours 1 ☐ M 2 🛛 F 70 Yrs. 214-32-5908 2/3/1936 Usual Residence of Decedent 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits Completed by Funeral Director 1 ☐ Yes 2 X No Worcester Berlin 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21811 6 Edgewood Dr. USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ∑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Specify: Specify: 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 5+ Teacher Education 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Dale Parsons Cathell Charlotte Hocker 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Lynnlee Dulau Friia 19 Dulaney Hills Ct., Cockeysville, MD 21030 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1 ☐ Burial 2XXCremation 3 ☐ Removal from State \* 4 ☐ Donation 5 ☐ Other (Specify) 7/10/2006 Cape Henlopen Crem. Frankford, DE 22. Name and Address of Facility The Burbage Funeral Home 108 William St., Berlin, MD 21811 23a. Pall 1. Enter the disease, or complications that aused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause a each line. Approximate Interval Between Onset and Death Immediate Cause (Final brain Stem stroke disease or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Due to (or as a consequence of) Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Dav Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No

/Medical **Examiner** or Attending Physician: The law requires that the death certificate be executed P.O. Box 68760, Division of Vital Records, after death Director:

**Funeral** 

Director

28e-f show

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and Mental Hygiene. Is marked other than "neturel",

Pages 1 and 2 should nent of Health and Men

permit. Pages 1 and 2 Department of Health ar Importent: If item 27 Is eny injury or other treu once.

**Physician** 

other treumatic event, the Medical Examinar must be notified at

be filed within 72 hours after death with the Maryland

Baltimore. Maryland

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Examiner Physician/Medical þ Be Completed Certification: To

									1 105	2 1 NC	,	1 1 1 62	210
						2	6. Place of Dea	th (C	heck only	one)			
Hospital:	1 Inpatient	2 🗆	ER/Outpatient	3 🗆 🛭	AOC	Other:	4 Nursing H	ome	5 🗌 Res	idence	6 Oth	er (Spec	ify)
28a.	Date of Injury (Month, Day Yea	ar)	28b. Time of		28c.	Injury at		28d.	Describe	how inju	ry occur	red	

7/8/06

27. Manner of Death 1 ☑Natural 2 ☐ Accident	5 Pending investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	2 No	28d. Describe how injury occurred
3 Suicide 4 Homicide	6 Could not be determined	28e. Place of Injury - At h building, etc. (Special	ome, farm, street, fact (y)	ory, office		28f. Location (Street and Number or Rural Route Number, City or Town, State)

29a. Certifier (Check only one)	1 ☐ Certifying Pk	ysician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. ner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause and manner stated.
	/	

29b. Signature and title of certifier 29d. Date signed (Month, Dey, Year)

DS3612 hypician

address of person who completed cause of death (Item 23a) (Type, Print) Healthway Dr Berlin, MD 9733 , MD

State Registrar

Medical

within 2

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [ ] [ ] [ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Jul 15, 2006 Year Conway 8:10 pm <sup>™</sup> 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Cumberland Nursing Center Cumberland Allegany If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Birthplace (State or Foreign Country) 1**X** M 2□ F 703-07-9687 81 Yrs Aug 10, МĎ Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits Allegany Cumberland 1X Yes 2 □ No 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 216 Seymour Street 21502 USA 12. Was Decedent Ever in U.S. Armed Forces? 1√ Yes 2 □ No IYes, Give Year or Dates: WW II 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: white 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Machinist CSX Transportation 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Charles W. Conway Clara Mae (Robertson) Conway 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, Mary Conway wife 216 Seymour Street Cumberland MD 21502 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Sunset Memorial Park 7/19/2006 Cumberland MD \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature / Funeral Service Lipans 22. Name and Address of Facility Scarpelli Funeral Home, PA 108 Virginia Avenue: Cumberland, MD 21502 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediat Cause (Final paucieas 15 a disease or condition resulting in death) Due to (or as a consequence f): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 🗀 Yes 2 100 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 2 No 2**/2**No 1 Yes 25. Was case referred to medical 26. Place of Death (Check only one) examiner' 2 Other: 1 Tyes 1 Inpatient 2 ER/Outpatient 3 DOA 4 Ursing Home 5 Residence 6 Other (Specify)

**Physician** /Medical **Examiner** 

Examiner

Physiclan/Medicai

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Be Completed

Medical Certification: To

27. Manner of Death

1 Natural 2 Accident

3 Suicide

29a. Certifier (Check only one)

4 Homicide

permit. Page Department of Important: If any injury or once.

**Physician** 

/Medical

10a State

MD

Director

Funeral

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Completed

Be

Examiner

**Funeral** 

Director

7 is marked othar than "natural", or Itams 23a or 28a-f show traumatic evant, I'm Medical Exantiner must be notified at

the Maryland

Baltimore, Maryland 21215-0036

Pages 1 and 2 should be filed within: nent of Health and Mental Hygiene. int: If item 27 is marked other than "

physician and the burial-transit The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760. page 2 s

certificate ! Hospital or Attending Physician: this After death. Diractor: filled within 24 hours a To the Funaral C the

U

31. Date filed (Month, Day, Year) State Registrar

29b. Signature and title of certifie

5 Pending

investigation

Could not be determined

28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

28f. Location (Street and Number or Rural Route Number, City or Town, State)

28d. Describe how injury occurred

28c. Injury at Work?

1 ☐ Yes 2 ☐ No

Carrington Court, Cumberland, Ad.

completed cause of death (Item 23a) (Type, Print)

ALMS 10000 JUL 2 1 2006

28a. Date of Injury (Month, Day Year)

			1 - For State Registra MEND#26per		-		artment of F		ınd M		- 211	05	23129
*		5.	Decedent's Name (First, Middle)		V,POO		imouto or	Douin		2. Date of Deat	h No. L		3. Time of Death
20	Physic		Adeline C.	Donovan						Month July	Day 4. 20	Year	10:50 <sup>ам</sup>
*	/Medi Examir		4a. Facility Name (If not institution	on, give street and num	ber)		4b. City, Town, o	r Location of	f Death	oury	4c. County		10:30
4/1.	9	great.	1134 Halesw	orth Drive			Rockvi:	lle			1	Montg	omery
	Funeral	7 200	5. Social Security Number		7. Age (In yrs. la	ast birthday)	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day,	Year)	9. Birthp	place (State or Foreign
E.	Director		579-26-4707	1□M 2 <b>⊠</b> F	85	Yrs.	Mortins Days	Hours	IVIIII.	Feb. 8,			ington, DC
	pu *		Usual Residence of Decedent  10a. State 10b. Count	v	10c City	, Town or Lo	cation						0d. Inside City Limits
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	28a-1	Director	Maryland Mon	tgomery		Chevy	Chase 10f. Zip Code				Og. Citizen of V	140	
	with a or	ā	4000 Oliver	Ctwoot			20815	=		1			my?
	leath	Funerai	11. Marital Status		dent Ever in U.S	S. 13.1	Was Decedent of H		in? (Spe	cify Yes or No-		USA e - Americ	can Indian
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215	within 7. ene. than 'n	Completed	(Specify only higher Elementary/Secondary (0-12)	est grade completed) College (1-	4or 5+)	(Give life. i	kind of work done of DO NOT use retired	during most d)	of workin	ng			•
21	d with giene	E C	Elementary/Secondary (5 12)	3	401 547	Но	memaker					Own	Home
	be filed tal Hygi d other event, L	Be	17. Father's Name (First, Middle	, Last)				18. Mother	r's Name	(First, Middle, N	faiden Suman	ne)	
<u>la</u>	should be nd Menta marked imatic ev	2	Joseph C. Car	rv				Ade	line	J. Duc	kett_		
Maryland	" = = =		19a. Informant's Name/Relation	ship (Type, Print)		19b. Mailir	g Address (Street	and Number	r or Rurai	Route Number,	City or Town,	State, Zip	Code)
	and ealth m 27		Kathleen M. D	iGilio/ Dau			Haleswort	h Dri					
Baltimore,	permit. Pages 1 and 2 should Department of Health and Mer Important: If tem 27 le marke any njury or other treumatic ange.		20a. Method of Disposition  1 D Burial 2 D Cremation	3 □Removal from S	000	ace of Dispo metery, cren	sition (Name of natory or other plac	э) Т	uly		20c. Location -	City or To	own, State
Ë	ntment of ntment: If to njury or p	1	4 □Donation 5XI Other (			of Hea	iven Cemete	ry	200	6 s	ilver S	Sprin	g, Maryland
Salt	permit. Departi Import any nj		21. Signature of Puneral Service	Licensee		FF FF	rancis dade	ss of Facility	ins	Funeral	Home :	Inc.	
Ш	20529		Linche	Whol	e	5	00 Univer	sity	Blvd	, W, Sı	lver S	pring	, MD 20901
			23a. Part1. Enter the disease, of shock, or heart failure. Lis	or complicitions that ca it only one cause on ea	used the death. ch line.	Do not ent	er the mode of dyin	g, such as c	ardiac or	respiratory arre	st,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Athe	roscle	rotic	como	liova	1501	ulan a	iseas	ie.	Onset and Death
	/Medical Examiner		resulting in death)	Due to (d	or as a conseque	ence of):	1.	,		1	, , , , , ,		1 10-
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	icate be executed physician and s the burial-transit	Examin	that initiated events resulting in death) Last	C. Due to (s	or as a conseque	onno of):							
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_	₩ O 00	ı w	IF FEMALE:	23c. If yes, outo	ome of pregnan	icv					201.0		
Box	that the death certif ed by the attending detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live bir	th 2 ☐ Fetal o	death 3	Ectopic pregnancy Other (specify)				Mo	te of delive inth	ny Day Year
P.O.		isi	1 □ Yes 2 ☒ No 9 □ Unknown	9□ Unkno			(4)		-				
	The law requires that the site has been signed by the page 2 should be detache	F Y	Part II. Other significant conditi	ions contributing to dea	ath but not result	iting in the ur	nderlying cause give	en in Part I.		23e. Did tob	acco use conti	ribute to th	e cause of death?
ds.	uires n sigr	D	Diabetes							1 Ye	s 2 🗆 No	3 🗌 Prob	ably 4 □Unknown
Records,	w requir been si should I	Completed by						-		24a. Was an	24h \	Nore auto	osy findings available
Re	he la e has ige 2	mg							_	autopsy	, E	prior to cor death?	npletion of cause of
Vital	ification, pa	e C	25. Was case referred to medica	al			-	00 00	.10			I ☐ Yes	2 X No
>	Physician: this certificatal director, participate in the control of the control	ToB	examiner?	Hospital:	patient 2 E	R/Outpatien	t 3 DOA Othe			Check only one	- Adam	iahte	r's residenc
ō	a Phy erthi	H	27. Manner of Death	28a. Date of		28b. Time of	28c. Injury Work		-	8d. Describe hov	The same	-q opocii)	
Division	Attending in death. ector: After by the fune	atio	1 Natural 5 ☐ Pendi 2 ☐ Accident invest	ng (Month igation	, Day Fear)	Injury		<br Yes 2.∐Ni	io				
Vis.	Atte	ific	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide detern	nined 289. Place	of Injury - At hon	ne, farm, stre	eet, factory, office		2	8f. Location (Str.	eet and Numb	er or Rura	Route Number,
Ö	el or s afte	Certification:	4   Homolog	Buildin	g, etc. (Specify)					City or Town,	State)		
	To the Mospitel or Attending Physicien: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier Certifyi	ng Physicien: To the I	oest of my know	ledge, death	occurred at the tim	ne, date and	place, ar	nd due to the ca	use(s) and ma	nner as st	ated.
	he Hin 24 he Fi	Medicai	one)	Examiner: On the ba	er stated.	on and/or inv	estigation, in my op	oinion, death	occurre	d at the time, da	te and place, a	and due to	the cause(s)
	To t	Σ	29b. Signature and title of certific	er /	M.	max	29c. License	number	^	29	d. Date signed	d (Month, I	Day, Year)
	20		Patricia	10ms/Ro	May,	1160	V5	1916	o'	, con	Julu	4.	2006
	6		30 Name and address of person	who completed cause	of dea (Item 2	23a) (Type,	Print) -//	n. 1		100 0	11.	11	nan
			Patricia Tor	nsko Ival	4 11/19	KOL	KVII/e	YIK.	e, 6	5-100, K	OCKVII	1/e, 1	YIV 20852
	Sta		31. Date filed (Month, Day, Year		gistrar's Signatu	ire	0.60 0		/				
At Safet	Registr	ar	JUL I	0 2006	Besse D	1- 15							,

### 06-04916 Michal Dvorak

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Time of Death Month Day July 10, 2006 2009 hrs **Medical Examiner** Michal Dvorak 4b. City, Town, or Location of Death Park Takoma Park c. County of Death 4a. Facility Name (if not institution, give street and number) Montgomery 7401 New Hampshire Avenue, Apt. 815 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9 Birthplace (State or **Funeral** ForeignCzech Months Min Davs Hours Director 219-39-3028 CountrRepublic 28 June 18, 1978 1 X M 2 Vre Usual Residence of Decedent 10d Inside City Limits 10c City Town or Location Ę 10a State 1 Yes XX No 28a-f show Takoma Park Maryland Montgomery hours after death with the Maryland Director 10e. Street and Numbe 10f Zip Code log Citizen of What Country? 7401 New Hampshire Avenue, #815 20912 USA **23**a Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black or items ? White, etc. Armed Forces? If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 X Never Married 2 Married 2x No Yes 10 SpecifyWhite Yes 2 X No specify: If Yes. Give Year Widowed Divorced ğ Decedent's Usual Occupation (Give kind of work done 6b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) other than " and 2 should be filed within 72 MD 21215-0036 12 Cook Restaurant/Food Servide 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Jiri Chvala marked Be Jirina Dvorakova 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20912 19a. Informant's Name/Relationship (Type, Print ) item 27 is n rraumatic Jirina Dvorakova/ Mother 7401 New Hampshire Avenue, #815, Takoma Park, tment of Health 20b Place of Disposition (Name of cemetery, 20a. Method of Disposition Date 20c Location - City or Town, State Baltimore, crematory or other place) Burial 2 X Cremation 3 Removal from State July 13, Pages Metropolitan Crematory portant: 2006 Alexandria, Virginia Other Specify. Donation 5 Francisd Sous of Collins Funeral Home Inc. 21. Signature of Funeral Simulae License 500 University Blvd, W, Silver Spring, MD 20901 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval Physician Between Onset and failure. List only one cause on each line /Medical Death Dilated Cardiomyopathy Examiner or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last Physician/Medical X UNPENDED AMENDED #4000 PMW MCCO /sician X 23a,27 g858 8-29-06 vt per me Division of Vital Records, P.O. Box 68760, attending phys for use as the by 23d Date of delivery IF FEMALE If yes, outcome of pregnancy . Was decedent pregnant in the 3 Ectopic pregnancy Live birth Fetal death Day past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? signed ğ 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? ✓ Yes 2 No Hospital or Attending Physician: 24 hours after death. 25. Was case referred to medical 26.Place of Death (Check only one) Be Hospital: 1 Other Nursing Home 5 Residence 6 Other: Scene ER/Outpatient 3 DOA Inpatient 2 1 V Yes ဥ 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27 Manner of Death 28c Injury at Work? 28d Describe how injury occurred Certification: 1 X Natural 5 Pending 1 Yes 2 No Director: 2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City 3 Could not be Suicide or Town, State) determined Homicide 29a. Certifier Certifying Physician; To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 2 1 and manner stated 29b. Signature and title of certifie 29c License number 29d. Date signed (Month, Day, Year) O.C.M.E. July 11, 2006 and address of person who completed cause of death (Item 23a) Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

OCME 2006

State

31 Date filed (Month, Day, Year)

8 2005 2. Registrar's Signature

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 60000 Dean Phyllis 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Allegany 12512 Sunshine Drive SE Cumberland If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Dec 2, 1930 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number 6. Sex 1 M 2 □ F NE Country) 75 215-26-9556 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County Cumberland Allegany 1 ☐Yes 2 ☐ No MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21502 USA 12512 Sunshine Dr. SE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 Yes 2 No Specify: white Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) own home 12 homemaker 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Grace (Brotemarkle) McCarty Howard McCarty 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) husband 12512 Sunshine Dr S.E. Cumberland MD 21502 Milford Dean Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State 7/19/2006 Hillcrest Memorial Park MD Cumberland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or hear failure. List only one cause op each line. Approximate Interval Between Onset and Death 1 lerc Immediate Cause (Final Ke ta YVS disease or condition resulting in death) 20 Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Due to (or as a consequence of): IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year in the past 12 months? Day

**Physician** /Medical Examiner attending physicien and for use as the burial-transit

**Physician** 

/Medical

Examiner

Director

Be Completed by Funeral

ဝ

Examine

Completed by Physician/Medical

Be 70

Certification:

Medical

**Funeral** 

Director

to the Hospitel or Attending Physician: The law requires thet the death certificate be executed Division of Vital Records, P.O. Box 68760, ል certificate this After this funeral d

within 24 hours efter death.

To the Funarel Director: All completely filled in by the ful

1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	3 3 3 3 3 3 3			
Part II. Other significant conditions o	ontributing to death but not res	sulting in the underlying	g cause given in Part I.	23e. Did tobacco u 1 ☐ Yes 2	se contribute to the cause of death? No 3 Probably 4 Unknow
				24a. Was an autopsy performed?	24b. Were autopsy findings availab prior to completion of cause of death? 1   Yes 2   No
25. Was case referred to medical			26. Place of De	eath (Check only one)	
examiner? 1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatient 3□	DOA Other: 4 Nursing	Home 5 Residence 6	G □Other (Specify)
27. Manner of Death    Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury M	28c. Injury at Work?	28d. Describe how injury	y occurred
3 Suicide 6 Could not b 4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci		ory, office	28f. Location (Street and City or Town, State)	d Number or Rural Route Number,
	niner: On the best of my kniner: On the basis of examination and manner stated.				and manner as stated. place, and due to the cause(s)
29b. Signature are title of certifier	4		29c. License number  Dou 33 2 P		e signed (Month, Day, Year)
30. Name and address of person who	completed cause of death (Ite	m 23a) (Type, Print)			0

3

State Registrar

31. Day Mill Gupta M.D.

2006

			For State Registrar	State o	f Maryland		artment of H rtificate of L		nd Me		iene	00	5 23	3 1 3	32
	Physici	e -	1. Decedent's Name (First, Middle,	.ast)					2	2. Date of Deat Month	h Day	Ye	ar	e of Dea	uth
	/Medic				an Edward	ds				July	16	200		.3 A	A M
	Examin	er	4a. Facility Name (If not institution, g		mber)		4b. City, Town, or	Location of	Death			ounty of D	Death		
			Union Hospita  5. Social Security Number 6	Sex	7. Age (In yrs. la	st birthday)	E1kton If Under 1 Year	If Under 24	4 Hrs. 8	8. Date of Birth		ecil	Birthplace (St.	ate or For	reian
	Funeral Director		223-46-5038	1□M 2∭ F	67	Yrs.	Months Days	Hours	Min.	JAN 16,	<sup>Year)</sup> 193		Country) Virgini		
	pu ,		Usual Residence of Decedent		100 City	Taura and a							104 1-04	- City Li	
	anyla	'n	10a. State 10b. County			Town or Lo	cation						10d. Insid	ecity Lin Yes 2 [∑	
	28a-f	Director	Maryland Cecil  10e. Street and Number		E.	1kton	10f. Zip Code			10	On Citize	n of What	t Country?		1
	Sa or		408 Union Chu	ch Road			21921						States		
	death	Funeral	11. Marital Status		edent Ever in U.S	13.	Was Decedent of Hi	spanic Origi	in? (Spec	rfy Yes or No-		Race - A	American India	٦,	
9	after or Ita	/Fu	1 Never Married 2 Married				1 ☐ Yes 2 🛣 No	Specify:	rueito Ni	ican, etc.)	S	black, v	Vhite, etc.		
9	filed within 72 hours after death with the Maryland Hygiene. the than "natural", or Itams 23a or 28a-f ahow ent, Ita Madical Examinat must be notified at	d by	XX Widowed 4 □ Divorced	Year or D	ates:	- 1				1 .			White		
7-	n 72 "nat	olete	15. Decedent's (Specify only highest	grade completed)		(Give	dent's Usual Occupa kind of work done d DO NOT use retired,	luring most of	of working	g	160. Kind	or Busine	ess/Industry		
212	with iene.	Completed	Elementary/Secondary (0-12)	College (	1-4or 5+)	Ins	spector				Rub	ber 1	Product	s	
D	e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, La	st)						(First, Middle, N	faiden Su	ımame)			
ylaı	Menta	To	Alfred Charles					Myr	tle I	Davis					
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural" or Itams 23a or 28a-f ahow any injury or other traumatic avent, Ita Miscigal Examinat must be notified at ance.		19a. Informant's Name/Relationship				ng Address (Street a								
e,	1 and Health em 27 ther t		Gregory W. Osboz	ne/Son	20b. Pla		Jnion Chur esition (Name of matory or other place								
Baltimore,	ages int of t: if it		1 Burial 2 Cremation 3 4 Donation 5 Other (Spe				matory or other place S & Co. Inc.	3	u1y <sup>□</sup> 3 .006				or Town, Stater,		
Ħ	artme ortan injur		21. Signature of Funeral Service Lie		11.71.					1 D	renn	sylv:	anıa		
ä	Depa Impo any ii		Manuella	2. 4	cha	10	Name and Address LCKS Home 03 W. Stoc	ckton	Stre	et, Elk	A. ton,	Mar	yland 2	1921	L
	Presician /Medical Examiner		23a. Part1. Enter the disease, or or shock, or heart failure. List or Immediate Cause (Final disease or condition resulting in death)	mplications that only one cause on a Due to	caused the death. each line.	Do not ent	er the mode of dying	g, such as ca	ardiac or	respiratory arre	est,			mate Betweer ind Death	
8760,	ate be executed hysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Ne	(or as a conseque	5 +	lung o	ave	ben	e moi	YOU	,			
.O. Box 6	The law requires that the death certific ste has been signed by the attending pl page 2 should be detached for use as:	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1☐Live t	tcome of pregnan birth 2  Fetal c nant at time of dea own	death 3[	Ectopic pregnancy Other (specify)	-		111	236	d. Date of Month	delivery Day	Year	
<u>α</u>	w requires that been signed b should be deta	þ	Part II. Dther significant condition	s contributing to d	eath but not resul	ting in the u	nderlying cause give	en in Part I.	_	23e. Did tob	_		te to the cause		
Il Records,		Completed								24a. Whas ar autops perform 1 Yes 2	/				
Vital	Physician: The rthis certificate hiral director, page	Be	25. Was case referred to medical examiner?	Hospital:			othe Othe	ar.		(Check only one					
o	ding Ph J. After th funeral	tlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investiga	28a. Date (Mon		:R/Outpatier 28b. Time o Injury	f 28c. Injury Work	4 🗆 19013	28	e 5 Reside			Specify)		
Division	al or Attending s after death. I Director: After d in by the fune	Certification:	Z Accident investiga 3 Suicide 6 Could no 4 Homicide determin	be 28e. Place	of Injury - At honing, etc. (Specify)	ne, farm, sti	reet, factory, office		28	Bf. Location (Sti City or Town	reet and f , State)	Number o	r Rural Route	Number,	
	To the Hospital or Attent within 24 hours after deatl To the Funerel Director: completely filled in by the	edical C	29a. Certifier (Check only one) Certifying 2 Medical Ex	aminer: On the b	e best of my know easis of examination oner stated.	rledge, deat on and/or in	h occurred at the tim vestigation, in my op	e, date and pinion, death	place, an	nd due to the ca	use(s) ar ite and pl	ace, and	r as stated. due to the cau	se(s)	
)	To the Comp	Σ	29b. Signature and title of certifier	180	m		29c. License		75	56	7	signed (M	ponth, Day, Yea	5	
	8		30. Name and address of person with	عصرص	mimi	5	Print) 223 C	vm	air	56 1 St.	E	IKt	on, d	D	
-	Sta Registi		31. Date filed (Month, Day, Year)  JUL 2 4 20	06	Registrar's Signatu	ile ear	elle 1								

			. For	State of N							•	iene	0.0.0	0010	73
		•	1 - State Registrar			Ce	rtificate	e of L	Death		Re	eg. No.	UUt	23/3	3
	Physicia		1. Decedent's Name (First, Middle, Las							2.	Oate of Deat Month	h Day	Year	3. Time of Death	
	/Medic		IDA PEARL FI				T		Landing 4		JULY 2			10:50 p	М
	Examin		4a. Facility Name (If not institution, given HOLY CROSS HOSPITA		r)				Location of			4c. C	ounty of Oea		
			5. Social Security Number 6. S		Age (In vrs.	last birthday			ER SPR		Date of Birth		MONTG 9. Bir		ian
	Funeral Director	ŀ	127-38-4965	_M 2X1F	89	Yrs.	Months	Days		Min	Date of Birth (Month, Day, )/11/19	Year)	C	thplace (State or Foreigountry) TN	
			Usual Residence of Decedent								,,				_
	iryian show	_	10a. State 10b. County		10c. Ci	ty, Town or L	ocation							10d. Inside City Limit	
	Ba-f	Scto	MARYLAND MONTGOME	RY					ER SPR	ING		0- 0:1:	4.14/5 -4.00		
	with it	2	10e. Street and Number	D			10f. Zip	Code	20904		'	ug. Cilize	un of What C		
	death with the Maryland ms 23a or 28a-f show rmust be notified at	Funeral Director	2505 MUSGROVE ROA	12. Was Decede	nt Ever in U	l.S. 13.	Was Deced	ent of Hi			v Yes or No-	14		arican Indian,	
	riter o	핊	1 ☐ Never Married 2 ☐ Married	Armed Force	s?					Puerto Rid	y Yes or No- an, etc.)		Black, Whi		
2	be lied within 72 hours after death with the Marylar Hygiene. d other than "neturel", or liems 23a or 28a-f show svent. It a Madical Examination must be notified at	þ	3	If Yes, Give Year or Date:	s:		1 Yes	2 <u>K</u> J No	Specify:			S	pecify: V	VHITE	
9500-61212	netur dical	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)		(Give	dent's Usua kind of wor	k done d	during most o	of working		16b. Kind	of Business	/Industry	
7	within 72 ene. than "net	m	Elementary/Secondary (0-12)	College (1-4d	or 5+)		DO NOT us			-			D I I C 1 M 7		
	Hygie V Hygie other t	ပိ	17. Father's Name (First, Middle, Last)	5+		PUBLIC	SCHO	OL			First, Middle, I		DUCAT] umame)	LON	
ä	·	To Be	MARCUS COHEN								ANDEL				
Maryiand	shoul nd Ma mari	Ě	19a. Informant's Name/Relationship (	Type, Print)		19b. Mail	ing Address	(Street a			loute Number	; City or 1	Town, State,	Zip Code)	
	es 1 and 2 should of Health and Me I Itsm 27 Is mark r other traumatic		CARL W. FRIEDLAND	ER/SON		1535	9TH S	T, N	'IANHAT	TAN B	EECH,	CALI	FORNIA	90266	l l
w .	Te Hand		20a. Method of Disposition 1 □xBurial 2 □ Cremation 3 □	Removal from Sta		Place of Disp cemetery, cre	osition (Nan ematory or o	ne of ther plac	e)	Date	•	20c. Loca	ation - City or	Town, State	
Ĕ	Pages ment of ant: If Its ury or o		4 Donation 5 Other (Specif		" JUI	DEAN MI	EMORIA	L GI	ons   0	7/05/	2006 0	LNEY	, MARY	LAND	
šait	permit. Pages Depertment of t Important: If Its sny Injury or o once.		21. Signature of Funeral Service Licer	nsee		$\mathbf{D}_{\mathbf{z}}^{2}$	2. Name an ANZANS	d Addres	s of Facility	RG ME	EMORIAI	CHA	PELS,	INC.	
_	<u>v</u> ∪ ≥ ⊕ α		(Alebia)	l		11	170 RC	CKV.	ILLE P	'IKE,	ROCKVI	LLLE,	MARY	LAND 20852 Approximate	2
H			23a. Parti. Enter the disease, or com shock, or heart failure. List only	one cause on each	i line.			e or ayın	g, such as ca	ardiac or re	espiratory arri	<b>85</b> 1,		Interval Between Onset and Death	
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a. RESPIR			RE								
	Examiner			SEPSIS	as a consec	quence or):									
	- 10	Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a consci	quanta of):									
	cuted nd ransit	Examiner	that initiated events	c. BILATE	RAL L	EG CEL	LULITI	S							
,09	te be executed ysicien and ie burial-transit		resulting in death) Last	Due to (or	as a consec	quence of):									
		dicai		_ d											
9 ×	The law requires that the death certificate sie has been signed by the attending phy page 2 should be detached for use as the	Completed by Physician/Med	IF FEMALE:	23c. If yes, outcor	ne of prean	ancv	-					23	d. Date of de	livery	
Box	atten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth	2 Fet	al death 3	□Ectopic pr					23	Month	Day Year	į.
o.	at the de by the a	hysi	1 ☐ Yes 2 📉 No 9 ☐ Unknown	9□ Unknowr	1										
ري. ص	res that igned to be det	y P	Part II. Other significant conditions		h but not re	sulting in the	underlying c	ause givi	en in Part I.		23e. Did tol	bacco use	o contribute 1	o the cause of death?	
Vital Records,	w require been sig should b	per	ACUTE RENAL FAILUR	RE			<del>_</del>				1 □ Ye	es 2 🗆	No 3□P	robably 4 X Unknow	٧n
ပိုင်	law re as be 2 sh	pie	ISCHEMIC COLITIS								24a. Was a autops	SV V	prior to	utopsy findings availab	ole of
		Соп	DIABETES MELLITUS	TYPE 2							perform 1 ☐ Yes	med? 2X No	death? 1 ☐ Ye	s 2 No	
Vita	Iclan: sertific ector,	Be	25. Was case referred to medical examiner?	Hospital:				Oth	or	•	Check only on				
ō	Attending Physician: r death. sctor: After this certific. by the funeral director,	.To	1 ☐ Yes 2 ☑ No 27. Manner of Death	1 Inp		ER/Outpatie		, A	4   Nurs		5 Reside			ecify)	
0	ding h. After fune	tion	1 ⊠Natural 5 ☐ Pending 2 ☐ Accident investigatio	(Month,	Day Year)	Injury	м	8c. Injun Worl	k?` Yes 2 □ N						
Division of	r Attanding P er death. rector: After by the funera	Ifica	3 Suicide 6 Could not b	28e. Place of			treet, factory	, office		28f			Number or F	Rural Route Number,	-1
á	s afte	Certification:	4   Homicide	building,	etc. (Spec	iry)					City or Town	n, Siaie)			- W
	To the Hospital or Attank within 24 hours after death To the Funeral Director: completely filled in by the			nysician: To the be											
	the H nin 24 the F nplete	Medical	one)	and manner		*									
	To Will	~	29b. Signature and title of certifier	7 1)		/	290		e number 2261				3, 20	ith, Day, Year) 106	
,	4		alon K	Ken	al	in	Dei-1						-		
			30. Name and address of person who ALAN R. SEGAL, MD	/ /		m 23a) (Pype RCLE,		R SPI	RING.	MARYI	AND 2	20906			
	Sta		31. Date filed (Month, Day, Year)												
	Regist		JUL 07	2006	Copped .	ature 6									

	1	For State Registrar	State	of Maryla	and / Depa <i>Cei</i>	artmen rtificat			ınd M		giene 0	06	23134
Physician	1	1. Decedent's Name (First, Middle		man J.	Garrett					2. Date of Dea Month	Day 16, 2006	Year	3. Time of Death
/Medica Examine		4a. Fecility Name (If not institution		umber)		4b. City,		Location o			4c. County		-l
Funeral Director		5. Social Security Number 219-32-4116	6. Sex 1 X M 2 □ F	7. Age (In y	rs. last birthday) 7 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Birth (Month, Day Aug 26		9. Birth Cou	place (State or Foreign intry) Maryland
yland	-	Usual Residence of Decedent  10a. State 10b. County		10c.	City, Town or Lo	cation							10d. Inside City Limits
Be-f st	010		Calvert			7		ort Re	public				1 ☐ Yes 2 🛣 No
With the Se of 2	ב	10e. Street and Number 5319 Broomes Island	Road			10f. Zip	Code	2067	6		10g. Citizen of	U.S./	•
IIS a	by runeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Marr 3 ☐ Widowed 4 ☒ Divorced	Armed F	2 🔀 No Sive		Was Deced If Yes, spec		spanic Origin, Mexican Specify:	gin? (Spe , Puerto I	cify Yes or No- Rican, etc.)	Bla	ce - Ameri ck, White, y: Blac	-
"natur	ered	15. Decedent (Specify only highes		f)	16a. Dece (Give	dent's Usua kind of wo DO NOT u	al Occupa rk done di	tion uring most	of working	ng	16b. Kind of B	usiness/Ir	ndustry
d withir piene. r then	Completed	Elementary/Secondary (0-12)  6	College	(1-4or 5+)	ine.	DO 1401 B.		enter			C	Constru	ıction
and be filed formal Hygerked otheric event.	o pe c	17. Father's Name (First, Middle,		Garrett				18. Mothe	r's Name	(First, Middle,	Maiden Sumar inkey Buc		
ges 1 and 2 should be filed within 72 hr to Health and Mental Hygiene. If Item 27 is marked other then "nature or other treumatic event, the Midfall		19a. Informant's Name/Relations Angela Wall/Daughte								1 Route Numbe 20676	r, City or Town,	, State, Zij	p Code)
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then any injury or other treumatic event, Item once.		20a. Method of Disposition  1 X Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (S)			o. Place of Dispo cemetery, crer Brooks UM	natory or o	ther place			12/06	20c. Location	-	own, State ard, MD
permit. Departn Importe any inju		21. Signature of Funeral Service	Licensee	10	22	Name ar Se 14	d Address well Fu	of Facility Ineral H	lome ch Roa	ad Prince F	rederick, l	MD 200	678
Physician /Medical		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one cause on	each line.	1620		e of dying	, such as	cardiac o				Approximate Interval Between Onset and Death
Examiner	e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlyin Cause iDisease or injury	b	o (or as a cons									
e be executed sician and burial-transit	ical Examiner	cause. Enter Underty in Cause, Disease or injury that initiated events resulting in death) Last	c. Due to	o (or as a cons	sequence of):								
fica Ph lica	Physician/medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 Live	utcome of pre birth 2 DF gnant at time on the community	etal death 3	∃Ectopic pi ∃Other <i>(sp</i>						ite of deliv	ery Day Year
uires that the signed by alld be detacted.	à	Part II. Other significant condition	ons contributing to	death but not	resulting in the u	nderlying o	ause give	n in Part I.			bacco use con es 2 □ No	tribute to t	the cause of death?
icien: The law requir certificate has been si rector, page 2 should	Completed									24a. Was a autop: perfor	sy med?	prior to co death?	opsy findings available impletion of cause of
icien: certifica ector.	D D	25. Was case referred to medical examiner?	Hospital: 4.5				Othe	-		(Check only or			
ng Phys	tion: 10	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pendin 2 Accident investig	28a. Dat	Tinpatient 2 e of Injury onth, Day Year	2 ER/Outpatier 28b. Time of Injury		8c. Injury Work	4   Nul	2	ne 5 Resid			fy)
To the Hospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certifical completely filled in by the funeral director.	Certification:	2 Accident Investig 3 Suicide 6 Could 4 Homicide determ	not be 28e. Plac	ce of Injury - A ding, etc. (Spe	at home, farm, str ecify)	-				28f. Location (S City or Town		oer or Run	al Route Number,
To the Hospitel or within 24 hours after To the Funerel Dir completely filled in	edical C		g Physician: To the Examiner: On the and ma										
To th withir To th comp	Me	29b. Signature and title of certifie	nua	the	2	290	License	number 25	47		29d. Date signe		
5		30. Name and address of person Mukesh Mathur, M					Md 206	378					
State Registra		31. Date filed (Month, Day, Year)	1 1 2006	Registrats Si	gnature	Spa	de						

			State of Maryland / Department of Health and I  State Certificate of Death		jiene 00	23135
	Physicia	an	1. Decedent's Name (First, Middle, Last)	2. Date of Dea Month	Day Yea	3. Time of Death
	/Medic	al	KATIE JANE GIFFORD  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Deatl	July	2 2 2 4c. County of De	
	Examin	er	SHADY GROVE ADVENTUT HOSPITAL ROCKVILLE, MARY		MONTE	,
	Funeral Director		5. Social Security Number  6. Sex 1 Months 1 M 2 F  7. Age (In yrs. last birthday) Yrs. If Under 1 Year If Under 24 Hrs. Months Days Heurs Min 3 U  Usual Residence of Decedent	(Month, Day	Year) 9. B	irthplace (State or Foreign Country) MARYLAND
	how how		10a. State 10b. County 10c. City, Town or Location	.4		10d. Inside City Limits
	he Ma	Funeral Director	Mb HOWARD COLUMBIA, MARYLA  10e, Street and Number 10f, Zip Code		log. Citizen of What (	1 Yes 2 No
	with t		12235 LITTLE PATUXENT BARKWAY #K 21044	,	log. Citizen of What C	A
	ems 2:	inera	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. Was Decedent of Hispanic Origin? (S. If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No- to Rican, etc.)	14. Race - An Black, Wh	nerican Indian,
36	within 72 hours after death with the Maryland ene. Than "natural" or Items 23a or 28a-f show the Medical Examinar must be natified at	oy Fu	1 Never Married 2 Married 1 Yes 2 No If Yes, Give 1 Yes 2 No Specify: Year or Dates:		Specify:	NHITE
21215-0036	72 hou natura	Completed by	15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of work	rkina	16b. Kind of Busines	s/Industry
121	within and the	mple	Elementary/Secondary (0-12) College (1-4or 5+)	9	None	
d 2	i filed v I Hygie other i	a		me (First, Middle,		
Maryland	Mental Mental arked affic ev	To B	KEITH HARON GIFFORD JENN	IFER	JEWEL	
Mar	12 should hand 7 is muttraum		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Ru  19b. Mailing Address (	+ 0	r, City or Town, State ARKWAY	, Zip Code)
ře,	t Healt itam 2		20a. Method of Disposition 20b. Place of Disposition (Name of cametery, crematory, or other place)	Date P	20c. Location - City	or Town, State
altimore,	Page nent o ant: If		1 Burial 2 XI Cremation 3 Li Hemoval from State	7/2006	Brentwoo	d, MD
Balt	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygenor. Department of Health and Mental Hygenor and procedure if filem 27 is marked other than "natural", or flems 23a or 28a-1 show any injury or other traumatic event, It a Medical Examinar must be notified all once.		21. Signature of Fundal Service (cense)  Simple Tribute Fundant 1040 Rockville Pike			
			23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac shock, or heart failure. List only one cause on each line.	c or respiratory arr	est,	Approximate Interval Between Onset and Death
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)  a			
	Examiner					
	be tist	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury			
<u>,</u>	execut n and ial-trar	Examiner	that initiated events c			
8760,	cate be executed physician and the burial-transit	dlcal	d			<u> </u>
9	ding p	/Mec	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of d	elivery
O. Box	es that the death certifi igned by the attending I be detached for use as	by Physician/Me	23b. Was decedent pregnant in the past 12 months?  1  Yes 2 No 9 Unknown  1 Live birth 2 Fetal death 3 Ectopic pregnancy in the past 12 months?  4 Pregnant at time of death 5 Other (specify)		Month	Day Year
o,	law requires that as been signed b 2 should be deta	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did to	,	to the cause of death?
Vital Records,	v require been sig should t	ted		1 🗆 Y		Probably 4 Unknown
Rec	9 4 9	Completed		24a. Was a autops perfor	sy prior to med? death'	autopsy findings available completion of cause of
Ital	ician: Th certificate rector, pag	a)		1 ☐ Yes ath (Check only or		es 2 🛣 No
of V	iding Physician: th. After this certifica funeral director,	To B			ence 6 Other (Sp	pecify)
ono	ding P. h. After I	tlon;	27. Manner of Death  1  Natural 5  Pending 28a. Date of Injury (Month, Day Year)  28b. Time of Injury 28c. Injury at Work? 1  Yes 2  No	28d. Describe no	ow injury occurred	
Division	ter for the	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	28f. Location (S. City or Tow	treet and Number or and, State)	Rural Route Number,
D	To the Hospital or At within 24 hours after or To the Funaral Dirac completely filled in by		29a. Certifier  (Check only   Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred.)	e, and due to the curred at the time.	ause(s) and manner	as stated.
	o the lithin 24 o tha F	Medical	one) and manner stated.  29b. Signature and title of certifier 29c. License number		29d. Date signed (Mo	
	F 3 F 8			10	July 2	2 2006
				M - 1 0	( D.	2 2006 Roukville
	Sta	ite	30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Shooty Grove Adventist Hospitol, 9901  31. Date filed (Month, Day, Year)  JUL 10 2006  32 Registrar's Signature	meal col	. U. U.,	MOUNTLE
	Registi		JUL 10 2006 Server S. Aprile			

Boby girl Gifford

		1 _ State	ite of Maryland / Dep	artment of Health and ertificate of Death			23136
		Registrar  1. Decedent's Name (First, Middle, Last)	06	Tuncale of Dealit	Reg. I	No.	3. Time of Death
Physic	ian		_1_1 .		Month [	Day Year 2006	
_/Med		Janet Lucille Grossni 4a. Facility Name (If not institution, give street a		4b. City, Town, or Location of Deat		4c. County of Death	1:45 P <sup>w</sup>
Exami	ner					,	
		5. Social Security Number 6. Sex	7. Age (In yrs. last birthday	Frederick If Under 1 Year If Under 24 Hrs	8 Date of Birth	rederick 9. Birthp	lace (State or Foreign
Funeral Director		215-44-9384		Months Days Hours Min.	(Month, Day, Yea	ar) Cour 1945 Mary	lace (State or Foreign try)
		Usual Residence of Decedent	00		Dec. II,	1945 Hary	Lanu
/land		10a. State 10b. County	10c. City, Town or L	ocation		1	0d. Inside City Limits
Man	ţ	Maryland Frederick	Frederick				1∭Yes 2□No
1 the	Director	10e. Street and Number	rrederiek	10f. Zip Code	10g.	Citizen of What Cour	ntry?
3 with	0	2125 Wainwright Court	. Unit RR	21702	USA		
ms 2	Funerai	11 Marital Status 12. Wa	as Decedent Ever in U.S. 13.	Was Decedent of Hispanic Origin? (S	specify Yes or No-	14. Race - Americ	
The state of the s	Ē	1 X Never Married 2 Marned 1 [	med Forces? □Yes 2⊠No	If Yes, specify Cuban, Mexican, Puer	to rican, etc.)	Black, White,	etc.
urs a	b		res, Give ar or Dates:	1 ☐ Yes 2 ☑ No Specify:		Specify: Whit	e
2 ho	Completed	15. Decedent's Education (Specify only highest grade comp	16a. Dece	edent's Usual Occupation e kind of work done during most of wo	dking 16b	. Kind of Business/Inc	
Pin 7	ple		Illege (1-4or 5+)	DO NOT use retired)	in, ing		
d wit	NO.	12	• .	r Lab Technician	Sc	ientific ]	Field
로 등 등 등 로	Be	17. Father's Name (First, Middle, Last)		18. Mother's Na	me (First, Middle, Maid	len Surname)	
Aenta Aenta tic e	10	Richard Eugene Grossn	ickle	Naomi He	idi Blicke	nstaff	
id y idility is 1.5.1.2.00.00 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. is marked other than "natural", or items 23s or 28s-f sflow sumatic event, the Medical Examiner must be notified at		19a. Informant's Name/Relationship (Type, Pr	int) 19b. Mail	ing Address (Street and Number or R	ural Route Number, Cit	y or Town, State, Zip	Code)
and 2 and 2 salth a n 27 is		Carol E. Wallick, dau	ghter 9301	B Opossumtown Pik	e,Frederic	k, Marylan	nd 21702
- ± 5 6		20a. Method of Disposition	20b. Place of Disp	osition (Name of ematory or other place)	Date 20c.	Location - City or To	wn, State
permit. Pages Department of I Important: If it any injury or o		1 X Burial 2 ☐ Cremation 3 ☐ Remove 4 ☐ Donation 5 ☐ Other (Specify)	ai from State	le Brethren Cem.	7/19/06 My	ersville.	Maryland
artm orta		21. Signature of Funeral Service Licensee		22. Name and Address of Facility $K\epsilon$			
permit. Departimport		Man history		06 East Church St	-		
_		23a. Part1. Enter the disease, or complication	s that caused the death. Do not er				Approximate
D		shock, or heart failure. List only one cau Immediate Gause (Final					Interval Between Onset and Death
Physician /Medical		disease or condition a. M	yocardial Infarc Due to (or as a consequence of):	tion			
Examiner				.m.f.o			
	ē	if any, leading to immediate	ypercholesterole Due to (or as a consequence of):	lliLa		11	
uted	Examin	cause. Enter Underlying Cause (Disease or injury					
exect pyer ap-tra	xa	that initiated events c. resulting in death) Last	Due to (or as a consequence of):				
cate be executed physicien and the burial-transit	dicail						
	g	U					1.00
that the death certificated by the attending period of the attending period of the as	Ž		ves, outcome of pregnancy			23d. Date of delive	erv
eath atte	Physician/M	in the past 12 months?		□Ectopic pregnancy □ Other (specify)		Month	Day Year
the d	lysi	1 ☐ Yes 2 X No 9 ☐ Unknown	Unknown				
The law requires that the death certificate has been signed by the attending pege 2 should be detached for use as		Part II. Other significant conditions contributi	ng to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	o use contribute to the	ne cause of death?
VII.d. The law requires the sician: The law requires the certificete has been signed rector, page 2 should be de	d by	Hypertension			1 ☐ Yes	2√∏No 3□Prob	ably 4 Unknown
w requires been sign should be	Completed				24a. Was an	24h Wara auto	psy findings available
e lav	E D				autopsy performed	prior to co	mpletion of cause of
Th : Th				· · · · · · · · · · · · · · · · · · ·	1 ☐ Yes 2 🔀	No 1 ☐ Yes	2□ No
OI VICAL Physician: Tribis certifice	Be	25. Was case referred to medical examiner?	ıl·	Other	ath (Check only one)		
Phys Phys	7	1 Tes 2 No	1   Inpatient 2   ER/Outpatie	#IL 3 DOX 4 Nursing P	dome 5 X Residence		y)
ing F After uner	on	1 XNatural 5 ☐ Pending	a. Date of Injury 28b. Time (Month, Day Year) Injury	Work?	28d. Describe how in	njury occurred	
Attending r death, ector: After by the fune	cat	2 Accident investigation 3 Suicide 6 Could not be		M 1 Yes 2 No	006 1		
OVISION  Tor Attending after death, Director; Afte	Certification;	4 Homicide determined	<ol> <li>Place of Injury - At home, farm, s building, etc. (Specify)</li> </ol>	treet, factory, office	28f. Location (Street City or Town, St	aria Number of Hura ate)	I Houle Number,
urs a		W. Carlotte			1		
DIVISION OF VIEW IN TO The Hospital or Attending Physician: The I within 24 hours after death, To the Funeral Director; After this certificete his completely filled in by the funeral director, page	edicai	(Check only 2 Medical Examiner: C	in the basis of examination and/or i	ith occurred at the time, date and place investigation, in my opinion, death occ	e, and due to the cause urred at the time, date :	e(s) and manner as si and place, and due to	tated. the cause(s)
F F F F F F F F F F F F F F F F F F F	Med	29b. Signature apd title of certifier	nd manner stated.	29c. License number	994	Date signed (Month,	Day Vaar
o T wit		200.00000000000000000000000000000000000	IN VI		250.	io o.giloo (moral)	
ch	ļ	Chang T	Aron #	D0036610	July	y 14, 2006	
8		30. Name and address of person who complet					
<u> </u>		Edward F. Fisher, MD,	56 Thomas Johns 32 Registrar's Signature	on Drive, Frederi	ck, Marylan	nd 21702	
S Regis	tate trar	31. Date filed (Month, Day, Zear) 2006	32 Hegistrar's Signature	2846			

		_	For State Registrar		Maryl		epartment Certificate			and M		eg. No.	2006	23137
	Physicia /Medic		1. Decedent's Name (First, Middle Nadara Dodson H		er						2. Date of Dea July 6		Year	3. Time of Death 12:19 Рм
	Examin		4a. Facility Neme (If not institution, Southern Maryla	•		nter	Clint	on	Location of			Pri		orges
	Funeral Director		5. Social Security Number 577–64–4250	6. Sex 1 ☐ M 2 ☐ F	60 Age (In	yrs. last birtho	Months		If Under Hours	24 Hrs. Min.	8. Date of Birth (Month, Day Aug 29	1945	9. Birthp Cour Mary	place (State or Foreign Pland
	aryiand •how	J.	Usual Residence of Decedent  10a. State  10b. County  Maryland Charl	es		. City, Town o							1	0d. Inside City Limits 1 ☐ Yes 🌂 No
	vith the M r or 28s-f	Directo	10e. Street and Number 2503 Lake Driv				10f. Zip	Code	206	01	1		Ac. County of Death Prince Georges  3. Time of Death Prince Georges  3. Jime of Death Prince Georges  4. Country Jand  10d. Inside City Limits 1	
36	2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. Is marked other than "netural", or Itema 23s or 28s-f show aumatic event, the Madical Examinar must be notilised at	by Funeral Director	11. Marital Status  1 Never Married 28 Marri 3 Widowed 4 Divorced	12. Was Dece Armed For	es? 2⊠No	in U.S.	13. Was Deced If Yes, spec		ispanic Ori n, Mexican Specify:	gin? (Spi i, Puerto	ecify Yes or No- Rican, etc.)	14.	Race - Americ Black, White,	can Indian,
Maryland 21215-0036	I within 72 hou lene. r than "netura the Medical E	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12) 12th	's Education		(6	ecedent's Usua Give kind of woi ife. DO NOT us cretary	k done d	durina mos.	t of work	ing			
and 7	ould be filed w Mental Hygier arked other ti atic event, in	To Be C	17. Father's Name (First, Middle, Donald Whitfiel						18. Mothe		e (First, Middle,	Maiden Su	mame)	
Mary	ith and M		19a. Informant's Name/Relationsl Harry J. Houser			19b. N 250	Mailing Address  3 Lake	(Street a	and Numbe	or Or Rura 418	Naldorf	r, City or To Mary	own, State, Zip Land 20	0601
Baltimore,	permit. Pages 1 and 2 should Department of Health and Men Important: If Item 27 ie marke any injury or other traumatic.		20a. Method of Disposition  1			camatani	isposition (Nam crematory or o UM C Ce	thar nisc	ery J				-	
Balti	permit. Departrimporte any Inju		21. Signature of Funeral Service	Licensee		_	22. Name an 4405 B1	d Addres	ss of Facilit	Rau Ro	sch Fun l. Port	eral Repub	Home lic MD	20676
8760,	Physician and prize be executed white prize the prize transit the prize transit transi	dical Examiner	shock, or heart failure. List only one cause on each line.										Interval Between	
.O. Box 6	The law requires that the death certifica ate has been signed by the attending ph page 2 should be detached for use as it	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outo 1 ☐ Live bi 4 ☐ Pregna 9 ☐ Unkno	th 2 🗍 int at time	Fetal death	3 ☐ Ectopic pr 5 ☐ Other (sp					230		•
ds, P	uires that signed b Id be deta	þ	Part II Other significant condition	ons contributing to de	ath but no	t resulting in t	he underlying c	ause give	en in Part I.			bacco use es 2□N		1/
al Records,		Completed	PHROVIC	MA						-		sy med? 2 □ No	prior to co death?	mpletion of cause of
of Vital	Attending Physician: r death. ector: After this certific by the funeral director,	To Be	25. Was case refered to medical examiner?  1  Yes 2 No  27. Manger of Death	Hospital: 1		2 ER/Outp			er: 4 ☐ Nu	ırsing Ho		ence 6		y)
Division of	tending I leath. tor: After the funer	Certification:	1 Alatural 5 Pendin 2 Accident investig 3 Suicide 6 Could	g (Monti	, Day Yea	ar) Inju	М		k? Yes 2□	No				
Ω	urs after or all Direction by		4 Homicide determ	buildir	g, etc. (S)	pecify)	n, street, factory				City or Tow	n, State)		
	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	Medical	(Check only 2 Medical one)	Examiner: On the ba and mann	sis of exa	/ knowledge, omination and/	or investigation	, in my o	pinion, dea	d place, th occuri	ed at the time, o	late and pla	ace, and due to	the cause(s)
)	To Your	₹	29b. Signature and title of certifie	10	M	<u></u>		0/	e number	06	:	Date s	S/C	Day, rear)
_	12		30. Name and address of person DR Rene	who completed cause	of death	(Item 23a) (T	ype, Print) Pi 50 a	tai	Nay	Ra	Chnto	00 (	M	20735
	Sta Regist		31. Date filed (Month, Day, Year)	1 1 2006	gistra's S	Signature	* An	180	•					

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene
Contificate of Death

Physicia edical Examii	ın/	Registrar  1. Decedent's Name (First, Middle,Last)				. No			
		Corey O. Ho	lland		2. Date of Death	Day Year	3 Time of Death 1940 hrs		
		4a Facility Name (if not institution, give street and number) Prince George's Hospital Center		4b. City, Town, or Location of Death Cheverly		4c County of Death			
Funeral Director			e (In yrs last birthday)  34 Yrs.	If Under 1 Year If Under 24Hrs Months Days Hours Min		(MM/DD/YYYY) 9. Birl			
		Usual Residence of Decedent			07/20/	1971 00			
Maryland <b>28a-f</b> show any <u>d at once.</u>		10a. State 10b. County Prince	10c. City, Town or Locati				10d Inside City Limits  1 Yes 2 YNo		
taryland 28a-f sk	Director	Maryland George's  10e. Street and Number	1 e m	nple Hills 10f. Zip Code	10	g Citizen of What Cour	11		
ith the Maryland 23a or 28a-f sho notified at once.		6005 Joyce Drive		20748		USA			
eath wi	Funeral	11. Marrial Status  1 Never Married 2 Married Armed Forces?  1 Yes 2		is Decedent of Hispanic Origin? (Spees, specify Cuban, Mexican, Puerto		14. Race - Ameri White, etc	can Indian, Black,		
s after d	ē	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1	Yes 2X No specify:		Specify Bla			
72 hours	eted	15 Decedent's Education (Specify only highest grade con Elementary/Secondary (0-12) College (1-4 or s	during m	t's Usual Occupation (Give kind of vost of working life. DO NOT use reti		16b. Kind of Business/I	ndustry		
3036 within iene ien than	Completed	12	Ва	rber	75 and 14 and 14	Hair Cu	tting		
21215-0036 uld be filed within 7 Mental Hygiene marked other than c event, the Medica	Be C	17. Father's Name (First, Middle, Last)  McAlwain	Claggett	Barbar	e (First, Middle, M a Jea		and		
<b>→</b> 2 P : 12 T	P	19a Informant's Name/Relationship (Type, Print) McAlwain Claggett/Fath		g Address (Street and Number or R Baliol Lane		per, City or Town, State			
e, MD and 2 sho Health and item 27 is traumati		20a Method of Disposition	20b. Place of Dispos	ition (Name of cemetery,		20c Location - City or			
Baltimore, permit Pages I an Department of Hea Important: If iten	Ц	1 XBurial 2 Cremation 3 Removal from St. 4 Donation 5 Other Specify	erematory or oth E. Jones	s Cemetery $7/1$	0/2006	Chesapea	ke Bch.,MI		
Baltimore, MC permit Pages I and 2 sl Department of Health ar Important: If item 27 injury or other trauma	- 1	21. Signature of Funeral Service Licensee	22. N 14	Name and Address of Facility Se 51 Dares Beac	well Fi	ineral Ho	me d.,MD20678		
Physician	П	23a Part I, Enter the disease, or complications that caused failure. List only one cause on each line.					Approximate Interval Between Onset and		
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  A Multiple Gunsho					Death		
		Sequentially list conditions,							
	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	equence of):						
ecuted and transit		events resulting in death) Last  Due to (or as a consider the consideration that consider the consideration that consideration the considera	equence of):						
60, ate be exect shysician an	Medical	UNPENDED AMENDED	· ·						
8760 ifficate b		IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcomes the second s		stal death 3 Ectopic pregna	ancy	23d Date of delivery	/ Day Year		
Box 687( c death certifica the attending pl df for use as the	Physician/	past 12 months?  1 Yes 2 No 9 Unknown 9 Unknown							
the c		Part II. Other significant conditions contributing to deat	h but not resulting in the u	underlying cause given in Part I	23e. Did tob	acco use contribute to	the cause of death?		
S, P.O uires that t n signed by Id be detac	ed by				1 Yes	2 No 3 Prob			
of Vital Records, ing Physician: The law require the securificate has been similared director, page 2 should be	Completed	<del></del>			autops perform	y prior to d	topsy findings available completion of cause of		
tal Rection: The certificate ector, page		25. Was case referred to medical		26.Place of Death (Check	1 ✓ Yes 2	No 1 ✓ Ye	es 2 No		
Vita hysicia this cer	lo Be	examiner?  1  Yes 2 No Hospital: 1 Inpatie	ent 2 🖊 ER/Outpatient		·	Residence 6 Other			
n of value Physics After the funeral	ion: T	27. Manner of Death  1 Natural 5 Pending  28a Date of Inju (Month, Day, V	found:	njury 28c. Injury at Work?  1 Yes 2 ✓ No	28d. Describe he Subject was	ow injury occurred shot			
Division tal or Attendi rs after death al Director: /	ficati	2 Accident Investigation Jul 2, 2006 28e. Place of In	1837 hrs njury - At home, farm, stree	et, factory, office building, etc.			ral Route Number, City		
Divisior Hospital or Attence 24 hours after death Funeral Director: stely filled in by the	Certification:	Suicide 6 Could not be determined (Specify) Local Street Pennsylvania Ave @ Donne							
Di To the Hospital of within 24 hours a To the Funeral I	Medical	29a. Certifier (Check only one)  Certifying Physician: To the best of mone)  Medical Examiner: On the basis of examiner:							
To wit.	Mec	29b Signature and title of certifier		29c License number		29d. Date signed (Mo	nth, Day, Year)		
		hy hu, imis		O.C.M.E.		July 3, 2006			
6		30. Name and address of person who completed cause of c Ling Li, MD Assistant Medical Examine		et, Baltimore, MD 21201					
	tate	31 Date filed (Month, Pay, Year), 7 2006 32. Figistre	ar's Signature	sole)					

			1- State of Manyland / Dept. State of Manyland / Dept. Registrer Cell	rtment of Health and M tificate of Death	Mental Hygi	ene 0 6	23139
	* 1977 - E	,	Decedent's Name (First, Middle, Last)		2. Date of Death	1	3. Time of Death
	Physici		Mary A. Hrebicek		June 3	0, 2006	10:10 PM
20 2 4 3	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	1	4c. County of Dear	
		1850 E	Manor Care Potomac	POTOMAC		MONTGOME	RY
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year   If Under 24 Hrs. Months Days Hours Min.	8. Date of Birth (Month, Day,	9 Bir	thplace (State or Foreign
	Director		165-10-4564 <sup>1□ M 2 XF</sup> 90 Yrs.	North Says	April 9,		PA
	pu *		Usual Residence of Decedent  199-State 10b. County 10c. City, Town or Lo	cation			10d. Inside City Limits
	Aaryli sho ed al	ō	IXC	Washington			1X Yes 2 No
	the N	Directo	Maryland Montgomery Potomac  10e. Sireet and Number 1120 20th St NW Ste 3005	10f. Zip Code	10	g. Citizen of What Co	nuntry?
	with sor	۵	10714 Potomac Tennis Lane	<del>20054</del> 20036		U.S.A.	,
	death with the Maryland rms 23s or 28e-f show	Funeral	11 Marital Status 12. Was Decedent Ever in U.S. 13.	Vas Decedent of Hispanic Origin? (Sp	ecify Yes or No-	14. Race - Ame	erican Indian,
_	riter	T.	Armed Forces?  1 X Never Married 2 ☐ Married 1 ☐ Yes 2 X No	f Yes, specify Cuban, Mexican, Puerto	Rican, etc.)	Black, Whit	
Š	urs a	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	I ☐ Yes 2 🛣 No Specify:		Specify: W	hite
2	2 ho	ted	(Capaily only highest grade completed)	lent's Usual Occupation kind of work done during most of work	ana .	6b. Kind of Business	/industry
2	Bn 'r	ple	Elementary/Secondary (0-12) College (1-4or 5+) Offic	OO NOT use retired.  of the Exec. Assort Master General	st. to		
7	filed wi Hygien thar th	Completed				US Postal	Service
Maryland 21215-0036	0 = 0 >	Be	17. Father's Name (First, Middle, Last)	18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
<u>X</u>	2 should be and Mental Is marked o	၉	Vito Hrebicek		zcchowsk		
a	2 sh and Is m			g Address (Street and Number or Run			
	and lealth m 27 her ti			Watson Pl., N.W.			
Ö	Total		LABURAL 2 Libremation 3 Linemoval from State	natory or other place)		Oc. Location - City or	
Ē	Pages Iment of Iant: If it		4 □Donation 5 □Other (Specify) Sacred He	art Old Cem. July			PA
Baltimore,	permit. Pages 1 and 2 should b Department of Health and Meniz Important: If Item 27 Is marked sny injury or other traumatics			Name and Address of Facility De 222 Wisconsin Ave			. 20007
	- 4:		23a. Park. Enter the disease, or complications that caused the death. Do not ent	er the mode of dying, such as cardiac	or respiratory arre	st,	Approximate Interval Between
	Physician		Immediate Cause (Final	_			Onset and Death
	/Medical		disease or condition resulting in death)  a. Advanced Dementi Due to (or as a consequence of):	a.			
-	Examiner		Goiter				
4-		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury  Due to (or as a consequence of):				
	cuted	Examiner	thal initiated events c. Hyperthylotusiii				
ó	an ar	EX	resulting in death) Last Due to (or as a consequence of):				
8760	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	dical	d. Atherosclerotic C	ardiovascular Disc	ease		
Ó	ing pl	Med	IF FEMALE:				
Вох	eath certific attending p	Physician/Me		Ectopic pregnancy		23d. Date of del Month	ivery Day Year
<u>.</u>	at the deby the a stached f	/sic	1 Yes 2 No 4 Pregnant at time of death 5 9 Unknown	Other (specify)			,
۵.	that the ed by detac	F.	Part II. Other significant conditions contributing to death but not resulting in the u	oderhyng cause given in Part I	23a Did tob	acco use contribute to	the cause of death?
Records,	ires tha signed d be dei	b b		donying daddo giron in r art i.			obably 4 🛣 Unknown
5	w require been si should t	Completed					
ec	e law has t	gu			24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
_	: The	S			perform 1 Yes 2		2 🗆 No
Vital	sician: The certificate hi rector, page	Be	25. Was case referred to medical examiner?  Hospital:	Other	h (Check only one		
ot	this al dii	- To	1 Inpatient 2 Envoutpatier	T SELECT 48 INDISTING THE	ome 5 Resider 28d. Describe how	nce 6 Other (Spe	cify)
L C	ding F h. After funer	lon	1 XNatural 5 ☐ Pending (Month, Day Year) Injury	Work? M 1 Yes 2 No	200. 0030100 1101	williary occurred	
S	Attender death	lica	3 Suicide 6 Could not be 28e Place of Injury - At home, farm, str		28f. Location (Str.	eet and Number or Ru	ural Route Number
Division of	after Dire	ertification:	4 Homicide determined building, etc. (Specify)	oot, radiory, onld	City or Town,	State)	arai riosio riambor,
	To the Hospitel or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifics completely filled in by the funeral director,	O	29a. Certifier 1⊠ Cartifying Physician: To the best of my knowledge, deat	occurred at the time, date and place,	and due to the car	use(s) and manner as	s stated.
	ne Ho	Medical	(Check only ane) 2 Madical Examiner: On the basis of examination and/or in and manner stated.	restigation, in my opinion, death occur	red at the time, da	te and place, and due	to the cause(s)
	To ti Withii To ti comp	Σ	29b. Signature and title of certifier.	29c. License number	29	d. Date signed (Mont	h, Day, Year)
)	10		>   Rute Votro M.I	D20274		July 1, 20	006
	, ,		30. Name and address of person who completed cause of death (Item 23a) (Type, Kirti Vonra, M.D.	Print)			
0.00	Antings in a		//10 Bradley Blvd. Bethesda, MD 2081	7			
	Sta Registi		31. Date filed (Month, Day, Year)  32 Registrar's Signature	well !			
1	riegist	I	OOL O ( COOO BURNES NO. 10)				

			1 - For State Registrar	State of Marylar		artment of H rtificate of			giene Reg. No.	23140
į	Physici		1. Decedent's Name (First, Middle, Last Olivia Kaye Halv	•				2. Date of De Month	Day Year	3. Time of Death
	/Medio Examin Funeral		4a. Fecility Name (If not institution, give Baltimore Washine 5. Social Security Number 6. 35	ton Medical (		4b. City, Town, of	If Under 24	Death  Hrs. 8. Date of Bird.  Min. (Month. Da	4c. County of Dea	And Der
	Director		Usual Residence of Decedent	M 280 F 59	Yrs.		110013	Dec. 10	, 1946 Nor	th Carolina
	Be-f ehov	Director	MD Anne Ar		ity, Town or Lo		verna P	ark		1 _ Yes 3 No
	h with the	ai Dire	10e. Street and Number 549 Devonshire C	ourt		10f. Zip Code	146		•	•
980	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mentel Hygiene.  If Gellem 27 is marked other then "natural", or items 23s or 28s-f show or other traumatic evant, the Medical Examinar must be notified at	by Funerai	11. Marital Status  1 Never Married 2 X Married 3 Widowed 4 Divorced	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cub	lispanic Origin an, Mexican, F Specify:	n? (Specify Yes or No Puerto Rican, etc.)		te, etc.
Maryland 21215-0036	thin 72 ho e. en "natur Medicel	Completed	15. Decedent's Edu (Specify only highest grad		(Give	dent's Usual Occup kind of work done DO NOT use retire	durina most of	f working	16b. Kind of Business	/Industry
d 21	filed wi Hygien other th ant, the	S Con	17. Father's Name (First, Middle, Last)	4	So	chool Tea		Name (First, Middle		n
ylan	2 should be filed within and Mentel Hygiene ie markad other then aumatic evant, the Mg	To Be	Werner Smith				Helei	n Diamond		
Z Z	and 2 sh ealth and m 27 ie m her traum		19a. Informant's Name/Relationship (T)  James Halvis/Husb							
2	Pages 1 a nent of Hea int: If item iry or othe		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ F 4 □ Donation 5 □ Other (Specify)	Removal from State AS	Place of Disponentery, creed Dury UI	esition (Name of matory or other place nited Church C	<sup>⇒e)</sup> Ji	uly 6,	20c. Location - City or	Town, State
Balti	permit. Page Department Important: It any injury o		21. Signature of Funeral Service Licens	4100	22	. Name and Addre	ss of Facility		-	
	Physician and // // // // // // // // // // // // //	dical Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consect.)  Due to (or as a consect.)  Due to (or as a consect.)	quence of):	er the mode of dyir	ig, such as cai	rdiac or respiratory ar	rest,	Approximate Interval Between Onset and Death
.O. Box 68	The death certific by the attending p ached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of pregni 1 □ Live birth 2 □ Fete 4 □ Pregnant at time of c 9 □ Unknown	aldeath 3 ☐	Ectopic pregnancy Other (specify)	,	Min. Dec. 10, 1946  Dec. 10, 1946  North Carolina    Outh Inside City Limits   1		
rds, P	quires that n signed b	ρ	Part II. Other significant conditions con	ntributing to death but not res		/	en in Part I.			
		Completed						autop perfor	sy prior to death?	completion of cause of
<b>=</b>	ysician: nis certifica director.	o Be	25. Was case referred to medicat examiner?  1 Yes 2 No	lospital: Inpatient 2	ER/Outpatien	it 3 DOA Oth				cutu)
o uo	ding Pr h. After tr funeral	ation: T	27. Manner of Death Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injur Wor		28d. Describe h		ony)
Divis	- 2	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At h building, etc. (Specia	ome, farm, str fy)	eet, factory, office		28f. Location (S City or Tow	itreet and Number or Run, State)	ural Route Number,
	To the Hospitel of within 24 hours aff To the Funeral Discompletely filled in	edical	29a. Certifier (Check only one)	sician: To the best of my kno ner: On the basis of examina and manner stated.	owledge, death ation and/or in	occurred at the time vestigation, in my o	ne, date and p pinion, death o	place, and due to the o occurred at the time, o	cause(s) and manner as date and place, and due	stated. to the cause(s)
	To the vithir comp	M	29b. Signature and title of certifier	0	11.1	29c. Licens			-	
			30. Name and address of person who co	ompleted cause of death (Iter	m 23a) (Type,	Print) DA	467	Hol Me Anu	Time 7	9147686
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 0 7 200	32 Registrar's Signa	ature de	ien 15c	My, e	e cero j	2/06/	

Halvis, Olivia,

<b>)</b>		1 - For AMEND#17 per FH State Registrer AACO HEALTH D  1. Decedent's Name (First, Middle, Last			artment rtificate					g. No.	006	2 3	
Physic /Med		Mayme Josephine V			,				uly	T <sub>e</sub>	2006		Брм
Exami	ner	4a. Facility Name (If not institution, give					Location of D a Park				nty of Death ne. Ari		
F		544 Knollwood Ros  5. Social Security Number 6. Se		yrs. last birthday)	If Under	1 Year	If Under 24	Hrs. g.	Date of Birth				or Foreign
Funeral Director			]M 2 <b>⊠</b> F	82 Yrs.	Months	Days	Hours N	Min.	(Month, Day, SC. 30,			place (State c ntry) higan	
Aaryland f show	ŏ	10a. State 10b. County MD Anne Art		c. City, Town or Lo Severi		k				10d. Inside City Lir 1 ☐ Yes 2 🖫			
r 28e-	rect	10e. Street and Number			10f. Zip	Code			10	g. Citizen o	of What Cou	ntry?	
th with	ai D	544 Knollwood Ro	ad			21	146				USA		
DAILITIOTE, INIGITISTICATION ZINIONO  permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "naturel", or iteme 23a or 28e-1 show any injury or other treumatic avent, the Medical Exercisin must be notified at any once.	t by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 🕉 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 XYes 2 □ No If Yes, Give Year or Dates: W		Was Deced If Yes, spec		spanic Origin n, Mexican, P Specify:	? (Specify Puerto Rica	Yes or No- an, etc.)	В	14. Race - American Indian, Black, White, etc. Specify: White		
within 72 h within 72 h lene. then "netu	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)		(Give	DO NOT us	k done d	uring most of	ng most of working			Kind of Business/Industry  Home		
Mary fatter X IX IS d 2 should be filed within 7 th and Mental Hygiene. 77 Is marked other than " treumatic avent, the Men	To Be Co	17. Father's Name (First, Middle, Last) William Jauhiane	<del>n</del> Jauhiai	nen					irst, Middle, M. a Lahti	aiden Sum	den Sumame)		
e, INIAL 1 and 2 sho Health and I tem 27 is mu		19a. Informant's Name/Relationship (Type, Print)  Glenn Vander Hook/Son  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  544 Knollwood Road Severna Park, MD 21146											
DallIIMORE, Dermit. Pages 1 a Department of Hez mportent: if item iny injury or othe		20a. Method of Disposition  1   ■ Burial 2 □ Cremation 3 □ F  4 □ Donation 5 □ Other (Specify)	Removal from State	Ob. Place of Dispo cemetery, cre Maryland	matory or of	ther place	Cem.	July 2006			n - City or T nsvil		
permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service Licens		Ba	2. Name and arrance 95 Gov	d Address	Sons, Cons, tchie					meral D 2114	Home 16
Physician /Medical Examiner	Examiner	23a. Payf. Enter the disease, or comp shock, or heart failure. List only o Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause, Disease or injury	ne cause on each line.	ast C				rdiac or re	spiratory arres	st,		Approximatinterval Betti Onset and I	ween
certificate be executed iding physician and ise es the burial-transit	dicai Exa	that initiated events resulting in death) Last											
death death e atter	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Unknown										Year	
law requires that the as been signed by the 2 should be detached.	þ	Part II. Other significant conditions co	ntributing to death but no	ot resulting in the u	ndertying ca	ause give	n in Part I.		23e. Did toba	10			death? Unknown
The The ate h	Completed								24a. Was an autopsy perform 1 ☐ Yes 2	- 1	b. Were auto prior to co death? 1  Yes	opsy findings ampletion of ca	available ause of
Physicien: rthis certifica	Be	25. Was case referred to medical examiner?	Hospital:			Othe			heck only one				
ald this	tion: To	27. Manner of Death	28a. Date of Injury (Month, Day Ye	2 ER/Outpatier  28b. Time of Injury		8c. Injury Work	4 U NUISII		Home 5 Aesidence 6 Other (Specify) 28d. Describe how injury occurred			( <del>y</del> )	
To the Hospitel or Attending I within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - building, etc. (S	At home, farm, st pecify)	reet, factory			28f.	Location (Stre City or Town,		mber or Rur	al Route Num	ber,
he Hospitel n 24 hours a he Funerel D	edical	one) 2 Medical Exam	sicien: To the best of m ner: On the basis of exa and manner stated.	mination and/or in	vestigation,	in my op	inion, death o	occurred a	it the time, dat	e and plac	e, and due t	o the cause(s	
To the within 2 To the complet	X	30. Name and address of person who co David ("Van Echo 31. Date filed (Month, Day, Year)	uEllo	MD	29c	OO S	number 5892	24	290	Date sign	ned (Month,	Day, Year)	6
		30. Name and address of person who co David C. Van Echo	ompleted cause of death	(Item 23a) (Type, 9MC, 69	Print)	orgi	a Are	Nu	, Was	hing	fon D	e 20	307
St	ate	31. Date filed (Month, Day, Year)	32. Figistrar's	Signature	Carl	5							

		•	For AMEND#29c per phyState State Registrer 7/7/06 AACO HEALITH 1	of Maryland	/ Depa		lealth a	-	Hygie	_	36	23142		
	Physicia		1. Decedent's Name (First, Middle, Last) Albert R. Hickman	771. CH				2. Date Mon July		Day 2	Year 006	3. Time of Death  11:15 a <sup>M</sup>		
	/Medic Examin		4a. Fecility Name (If not institution, give street and	number)		4b. City, Town, o	r Location of	Death	4c. County	of Death	L			
	Examin	C.	Charlestown Retiremen		7	Catons	sville			Bal	timo	re		
I	Funeral Director		5. Social Security Number 218-05-4534 6. Sex	7. Age (In yrs. last		If Under 1 Year Months Days	If Under 2	Min. 8. Date (Mon. July	of Birth oth, Day, Y	1918	9. Birthpi Coun Mary	lace (State or Foreign try) Yland		
	pu ,		Usual Residence of Decedent  10a. State 10b. County	10c. City, To	own or Loc	ation					1	0d. Inside City Limits		
	e Maryia sa-f ehov	ctor	MD Baltimore		nsvi	lle						1 ☐ Yes 2 ☑ No		
	th with th	Funeral Director	713 Maiden Choice Lane	Apt. # 5			228			. Citizen of W USA				
036	should be filed within 72 hours after deeth with the Maryland nd Mental Hyglene I marked othar than "returel", or items 23a or 28a-f show umatic event, the Medical Examinar must be nutified at	þ	Arme 1 Never Married 2 Married 1 MY If Yes	Decedent Ever in U.S. I Forces? es 2 □ No Give or Dates: WW I	1	Vas Decedent of H Yes, specify Cubi ☐ Yes 2 1 No		in? (Specify Yes Puerto Rican, e	or No- tc.)		Race - American Indian, Black, White, elc. pecify: White			
Maryland 21215-0036	ithin 72 ho se. sen "netur Medical	Completed	15. Decedent's Education (Specify only highest grade completed in the comp		(Give I	ent's Usual Occup kind of work done OO NOT use retire	during most d)	of working	16b. Kind of Business/Industry  Televisions			·		
2	filed w Hygier Sthar th	S	Repairman  17. Father's Name (First Middle Last)  18. Mother's Name (First, Middle Last)											
yland	should be fil and Mental H marked ott umatic ever	To Be	17. Father's Name (First, Middle, Last)  Roland R. Hickman  18. Mother's Name (First, Middle, M Ellen Milholla											
Jar		18	19a, Informant's Name/Relationship (Type, Print)	1		g Address <i>(Street</i> 02 Tufts						Code) , MD 21075		
e,	1 and Health Brm 27 ther t		Mary Fleshman/Daughte 20a. Method of Disposition						-	c. Location -				
Baltimore,	permit. Pages 1 and 2 Department of Health a Important; If item 27 is any injury or othar tra once.		1 Burial 2 Carmation 3 Removal f 4 Donation 5 Other (Specify)	om state	o Cre	sition (Name of natory or other pla matory	2	July 5, 2006		Baltin				
Ball	Departit Depart Import any in		21. Signature of Emperal Service Licensee	~	Ba		& Sons Ritchi	P.A. e Hwy.			rk Fi rk, N	uneral Home 1D 21146		
3760,  Nee be executed with the purial-transit in the purial-trans		Ilcal Examiner												
P.O. Box 68	Hospital or Attending Physician: The law requires thet the death certificat 24 hours after death. Funeral Director: After this certificate has been signed by the ettending phy lited in by the funeral director, page 2 should be deteched for use as the filled in by the funeral director, page 2.	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1							23d. Date of delivery Month Day				
	quires thet n signed b	ρ	Part II. Other significant conditions contributing	to death but not resulting	of the pr	nderlying cause giv	ven in Part I.	236		id tobacco use contribute to the cause of death?				
Division of Vital Records,	The law requir ete has been si page 2 should	Completed	ρ	abetu	n	ellit	m	-   _	. Was an autopsy performe Yes 2	d?	Vere autoperior to con leath?	psy findings available inpletion of cause of 2 No		
/ita	cian; ertific sctor,	Be	25. Was case referred to medical examiner?					of Death (Check	only one)					
<u></u>	physic this c	10			/Outpatien	1 3L DOA		sing Home 5				0		
N C	After funer	lon	1 □Natural 5 □ Pending (	ale of Injury Month, Day Year)	b. Time of Injury	Wo	rk? ]Yes 2∐N		SCIIDE HOW	injury occurr	90			
Jivisio	I or Attendater deatl Director:	Certification:	3 Suicide 6 Could not be determined 28e. F	lace of Injury - Al home uilding, etc. (Specify)	e, farm, str			28f. Loc	ation (Stre	et and Numb State)	er or Rura	l Route Number,		
_	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2	Medical Co	29a. Certifier (Check only one) 1 Certifying Physician: T 2 Medical Examinar: On I and											
)	To the within To the Comple	Me	29b. Signature and title of certifier	an i	WS	29c. Licens	se number 1	D20040	290	Date signed	(Month,	Day, Year)		
			30. Name and address of person who completed	11 -14	70	Print) Mu	eden	- Cho	nec	Can	e C	atensible		
	Sta Regist		31. Date filed (Month, Day, Year)  JUL 0 7 2006	2. egistrar's Signatur	4	noch .					Z	1226		

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day **Physician** CARLITA MURPHY JONES July 4, 2006 7:20P /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 21117 Tall Cedar Way Germantown Montgomery 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Jan. 9, 1921 Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🔀 F 85 Yrs. Director Maryland 216-16-5449 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits ir than "netural", or Iteme 23a or 28a-f ehow The Medical Examinar must be notified at 1 XYes 2 No Montgomery Germantown Directo 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? 21117 Tall Cedar Way 20876 U.S.A. permit. Pages 1 and 2 should be filed within 72 hours after death v Department of Health and Mental Hygiene. Important: If item 27 ie marked other than "neturat", or iteme 23a any injury or other traumatic event. Tra Medical Examinar must any once. Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. 1 ☐ Yes 2 **②**No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black ģ 3 Widowed 4 Divorced ted 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Comple Buffalo Board of Elementary/Secondary (0-12) College (1-4or 5+) Education Teacher 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Carl Murphy Vashti Turley 19a. Informant's Name/Relationship (Type, Print) Jones Jr Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Leeland N. 21117 Tall Cedar Way Germantown, MD 20876 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3X Removal from State 4 □ Donation 5 □ Other (Specify) Forest Lawn Cem 7/10/06 Buffalo, NY 21. Signature of Funeral Service License 22. Name and Address of Facility Snowden Funeral Home, P.A. 246 N. Washington St Rockville, MD20850 Part 1. Enter the disease, or complications that caused the death. De not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate
Interval Between
Onset and Death
Unknown Immediate Cause (Final disease or condition GASTRIC CANCER Physician /Medical resulting in death) Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed Due to (or as a consequence of): ed by the attending physician a detached for use as the burial-Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۵ should t 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? Sec autopsy performed? 1 ☐ Yes 2 🗗 No page this certificate 2 XNo 1 Yes director Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 AResidence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After Injury 1 Natural 5 Pending within 24 hours atter use....
To the Funaral Director; Aft 1 □ Yes 2 □ No investigation 2 Accident 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 \( \text{Homicide} \) the Hospital 1 🔀 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D25210 July 5, 2006 3 30. Name an ddress if person who completed cause of death (Item 23a) (Type, Print) Jerry E. Seals, MD 10700 Charter Dr Columbia, MD 21041 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 07 Registrar 2006

		1 - For State Registrar	State of Ma	ryland / Dep		ealth and M	lental Hy	giene Reg. No.	06 2	314
Physic /Medi Exami	cal	Decedent's Name (First, Middle, Last     Richard  Last  4a. Facility Name (If not institution, give	L. Johnson					4c. County	Year 006 11	me of Death:
Funeral Director		MEMORIAL         HOSPITA           5. Social Security Number         6. Se           234-64-3692         10           Usual Residence of Decedent		(In yrs. last birthday, 65 Yrs.	CUMBER  If Under 1 Year  Months Days	RLAND If Under 24 Hrs. Hours Min.	8. Date of Bir Month, Oa Apr 22		9. Birthplace (S	tate or Foreig
r death with the Maryland eme 23s or 28e-f ehow er roust be notified at	ector	MD 10b. County Allegar	ту	10c. City, Town or L LaV	ale			10d. Inside		
th with the 23s or 2 set be n	al Dire	10e. Street and Number 12301 Gramlich R	oad		10f. Zip Code	21502		10g. Citizen of \	Nhat Country? SA	
0 = 3	by Funer	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent E Armed Forces? 1  Yes 2  IN If Yes, Give Year or Dates:	ver in U.S. 13.	Was Decedent of Hi ff Yes, specify Cuba 1 Yes 2 No	spanic Origin? (Spanic Origin?) n, Mexican, Puerto Specify:	ecify Yes or No Rican, etc.)	Specify	e - American India ck, White, etc. Y: white	an,
within 9ne. then	Completed by Funeral Director	15. Decedent's Edi (Specify only highest grade Elementary/Secondary (0·12)	ication le <i>completed)</i> Coffege (1-4or 5-	(1-4or 5+) accountant			ing	usiness/Industry  Sap Lodg	e and	
build be filed Mental Hyginarked other atic event, in	To Be C	17. Father's Name (First, Middle, Last) Ford Johnson	, Maiden Suman SON	ne)						
nd 2 should lith and Men 27 is marke r traumatic		19a. Informant's Name/Relationship (T) Mary Johnson	<sub>(рв. Print)</sub> wife	19b. Mail 123	ing Address <i>(Street a</i> 301 Gramli	and Number or Rura ch Road	LaVa	er, City or Town,	State, Zip Code)	21502
Pages 1 en ment of Heel ant; If Item 2 lury or other		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)			uneral Home	e, P.A.	7/15/200	Cresa	City or Town, Sta	MD
permit. Departm Importa eny inju		21. Signature Funeral Service Licens	MU	1/1 2	<sup>2. Nam</sup> Scalpet 108 Viro	ที่ ⊈็น็ที่⊌ral Ho ginia Avenue			21502	
Medical Examiner per per per per per per per per per p	i Examiner	23a Fart. Enter the disease, or components of the components of th	Due to (or as a b.  Due to (or as a c.	a consequence of):	tery dv	g, such as cardiac c	or respiratory a	rrest,	Interva	xmate al Between and Death
the death certification by the ettending place as tached for use as t	Physician/Medicai	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	d23c. If yes, outcome of 1 University 1 at 1 9 Unknown	2 Fetal death 3	□Ectopic pregnancy □ Other (specify)				te of defivery onth Day	Year
quires thei		Part II. Other significant conditions co		t not resulting in the	underlying cause give	en in Part I.		obacco use cont Yes 2□No	ribute to the cause	e of death? 4 Unknow
	Completed by							osy ormed?	Were autopsy find prior to completion death?	
ng Phys fter this neral dii	ation: To Be	25. Was case referred to medical examiner?  1 Yes No  27. Manner of Death  Watural 5 Pending 2 Accident investigation	Hospital: 1 ☐ Inpatier 28a. Date of Injun (Month, Day	y 28b, Time o	of 28c. Injury Work	er: 4 Nursing Ho	eath (Check only one)  Home 5 Residence 6 Other (Specify)  28d. Describe how injury occurred			
To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Pface of Injubulding, etc.	ry - At home, farm, si . (Specify)	treet, factory, office		28f. Location (. City or To	Street and Numb wn, State)	er or Rural Route	Number,
Hospita 24 hours Funere etely fille	Medical C	29a. Certifier 1 Certifying Phy (Check only 2 Medical Exam	sicien: To the best of iner: On the basis of and manner stat	examination and/or it	th occurred at the time	ne, date and place, pinion, death occurr	and due to the ed at the time,	cause(s) and ma date and place,	inner as stated. and due to the car	use(s)
To the To the Complei	Me	29b. Signature and title of certifier	plomo		29c. License	e number			d (Month, Day, Ye	ar)
Ve		30. Name and address of person oc Sunil Gupta M.D	).	625	, Print) Kent Aven	ue Cumbe	eriand M	1D 21502	2	
St Regist	ate rar	31. Date filed (Month, Day, Year)		r's Signature	harte					

			For State Registrar	State of Maryl	and / Depa <i>Cei</i>	artment of F rtificate of	lealth and M <i>Death</i>		iene	06	23145
7 -	- J.	3	Decedent's Name (First, Middle, La	st)				2. Date of Deat	h		3. Time of Death
	Physici		Doris	Marie	Kr	orr		July 9,	2006	Year	11:07P.M
7 4	/Medic Examin		4a. Facility Name (If not institution, given				r Location of Death		4c. County	of Death	
			Frederick Memoria	al Hospital		Frede	rick		Frede	erick	
	Funeral		5. Social Security Number 6. S	□ M 200 F	yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month Day, Jan. 9, I	Year	9. Birthp Coun Mary	lace (State or Foreign
	S Director		215-28-2973 Usual Residence of Decedent	74	Yrs.			Jan.9,1	932	mary.	Land 
	land M		10a. State 10b. County	10c	City, Town or Lo	cation				1	Od. Inside City Limits
	Mary	ţ	Maryland Frederi	ck	Frede	rick					1 ∑Yes 2 □ No
	r 28a	Directo	10e. Street and Number			10f. Zip Code		1	0g. Citizen of V	Vhat Coun	try?
	23a c	a	2520 Waterside D	rive Suite 2	203	2170	1		USA		
036	be filed within 72 hours after death with the Maryland ital Hyglene. Id other than "natural", or items 23a or 28a-f show ovent, the Medical Exerciting Frant by Incillish at	by Funeral	11. Marital Status  1 Never Married 2 Marned 3 Widowed 4 Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:		Was Decedent of Hif Yes, specify Cuba 1 ☐ Yes 2 No	lispanic Origin? (Spi an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - Americ k, White, Wh:	
21215-0036		Completed	15. Decedent's E (Specify only highest gr		16a. Dece (Give	dent's Usual Occup kind of work done DO NOT use retired	ation during most of work	ing	16b. Kind of Bu	isiness/Ind	lustry
12	should be filed within of Mental Hygiene. marked other than matic event, Ire Mar	omp	Elementary/Secondary (0-12)	College (1-4or 5+)		memaker	2)		Ow	n Ho	me
	ifiled will Hygien other th	Be C	17. Father's Name (First, Middle, Last				18. Mother's Name	e (First, Middle, M	Maiden Sumam	10)	
<u>a</u>	uld be i Aental I rked o tic evs	To B	Felix H. Morris	on			Ida	Weine	1		
Maryland	2 should and Men is marke sumatic		19a. Informant's Name/Relationship				and Number or Rura				· ·
	5 = 7 ±		Dr. Norman J. Kno				e Dr. Sui				
altimore,	permit. Pages 1 at Department of Hea Important: If item any injury or othe once.	3	20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci	Removal from State	rederic	natory or other place k Cremato	ry 7/11	/2006	20c. Location - Frederi	ck,MD	
Ball	permit Depart Import any in		21. Signature of Funeral Service Lice				ss of Facility St umtown Pi				
i v	Pnysician /Medical		23a. Part Pentache disease, or consheck, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Due to lo as a con	L.	Poller	g, such as cardiac o	or respiratory arre	est,		Approximate Interval Between Onset and Death
	Examiner	_	Sequentially list conditions,	· Coma	X de	siese	-			1	pens
	ted nsit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a c s	seds ence of):	Done	=				000
<u>,</u>	icate be executed physicien and s the burial-transit	Exar	that initiated events resulting in death) Last	Due to (or as a con	sequence of):					_	
58760,	te be ysicie	dicai	(	_ d							
~		Ψ.	IF FEMALE:								
P.O. Box	Attending Physician: The law requires that the death certific refath.  *Geath.  *Clor: After this certificate has been signed by the attending p. the tuneral director, page 2 should be detached for use as so the tuneral director.	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 10 9 Unknown	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ f 4 ☐ Pregnant at time 9 ☐ Unknown	etal death 3	Ectopic pregnancy Other (specify) _	1		23d. Date Mor	e of delive nth	ry Day Year
	s that pned b	by Pi	Part II. Other significant conditions	contributing to death but not	resulting in the u	nderlying cause giv	en in Part I.	23e. Did tob	acco use contr	ibute to th	e cause of death?
ğ	w require been sig should b				· · · · · · · · · · · · · · · · · · ·			1 🗆 Ye	s 2 No	3 🗌 Proba	ably 4 []Unknown
Division of Vital Records,	ding Physician: The law ro.h. After this certificate has be funeral director, page 2 sh	Completed						24a. Was ar autops perform 1 \sum Yes 2	ned2	Vere autoportion to confice th?	osy findings available npletion of cause of
/ita	cian: ertific ector,	Be (	25. Was case referred to medical examiner?				26. Place of Death	h (Check only on	e)		
5	Physic this c	၉	1 Yes 2 No		ER/Outpatier		4   Nursing Ho	me 5 Reside			)
ב	ing F	lon	27. Manner of Death  1. Natural 5 Pending	28a. Date of Injury (Month, Day Yea	r) 28b. Time of Injury	Wor	yat k? Yes 2 □No	28d. Describe ho	w injury occurr	ed	
Si	or Attend after death Director: /	fical	2 Accident investigation 3 Suicide 6 Could not be determined	e Coo Blace of laiver	At home, farm, str			28f. Location (Sti	reet and Numbe	er or Rural	Route Number
<u>≥</u>	al or A s after il Dire	Certification:	4  Homicide determined	building, etc. (Sp	necify)	,,,		City or Town			
	To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in by	Medical C	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	nysician: To the best of my miner: On the basis of exam and manner stated.	knowledge, death	n occurred at the tirvestigation, in my o	ne, date and place, pinion, death occurr	and due to the ca ed at the time, da	use(s) and ma ite and place, a	nner as stand due to	ated. the cause(s)
)	To t To t	×	29b. Signature and title of certifier			29c. Licens	e number	29	Date signed	(Month, D	2006
7	9		14-A-06621 1	completed cause of death	(Item 23a) (Type,	Print) 200	Gleer Column	Die 7	nes	2184	44
1	Sta Registr		31. Date filed (Month, Day, Year)	32. Prgistrar's S	ignature	notes.					ı

		1 - For State Registrar	State of Marylar			of Death	Re	g. No.	16 23	
Physic	ian	Decedent's Name (First, Middle, Last     Donna Ray	Lytle				2. Date of Deat. July		3. Time of 4:30	
/Medi	cal	Donna Ray  4a. Facility Name (If not institution, give			4b. City, Tov	vn, or Location of Dea		4c. County o		71
Exami	ner	2145 Tamarac Ti			Lus			Cal	vert	
Funeral		5. Social Security Number 6. S 159-36-8688 1	ex 7. Age (In yrs. □ M 2	last birthday) Yrs.	If Under 1 Y Months D	ear If Under 24 Hi ays Hours Mi	n. (Month, Day,		Birthplace (State of Country)	
Director		Usual Residence of Decedent	A 00				Feb 2	1946	Pennsylv	'ani
tryland show	_	10a. State 10b. County		ty, Town or Lo	ocation				10d. Inside Cit	-
the Ma	Directo	Maryland Calver	rt Lus	уру	10f. Zip Co	do	10	0g. Citizen of W	1 Tes	<b>X</b> _110
3a or	i Dir	2145 Tamarac Ti	cail		206			•	States	
"natural", or Items 23a or 28a-f show	by Funerai	11. Marital Status  1 Never Married 2 Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 ☐ <b>X</b> o If Yes, Give		Was Decedent If Yes, specify	of Hispanic Origin? Cuban, Mexican, Pue Wo Specify:	(Specify Yes or No- erto Rican, etc.)		- American Indian, , White, etc. white	
d within 72 hours afgione.  yiene.  r then "natural", or		3 ☐ Widowed 4 ☑ Divorced	Year or Dates:	16a. Dece	dent's Usual O	ccupation		16b. Kind of Bus	iness/Industry	
d Z I Z I 3-0 filed within 72 ho Hygiene. other than "natur ent, Ibo Modical	Completed	(Specify only highest gra	completed) College (1-4or 5+)	(Give	kind of work d DO NOT use r	one during most of w atired)	orking			
0 2 0 -		7th 17. Father's Name (First, Middle, Last)		home	maker	18 Mother's N	ame (First, Middle, A	own ho		
0 7 5	To Be	Harry Jasper O				200	ice Mary			
d 2 should d 2 should th and Men (7 is marke treumatic	F	19a. Informant's Name/Relationship (	Type, Print)		-	reet and Number or I	Ru <i>ral Rout</i> e Number,	City or Town, S	itate, Zip Code)	
and 2 and 2 ealth a m 27 i		Lisa Sarikaya -		_			l Lusby,			
Datifiliole, Malylal permit. Pages 1 and 2 should b Department of Health and Ments Important: If item 27 is marked any injury or other treumatic e anges.		20a. Method of Disposition  1 □ Burial 2 ☑ Cremation 3 □  '4 □ Donation 5 □ Other (Specification)	y) Me	tropo	litan	Funeral	To 2006 Service		idria Virg	inia
permit. Departitimport. any inj		21. Signature of Funeral Service Licer	och _	440	05 Broc	mes Is. R	ausch Fune d. Port Re	public	MD 20676	
Physician /Medical Examiner		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a St	acle		Cell Cel	200	Canc	Approximate Interval Bety Onset and D	ween
uted d	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consec	quence of):						
cate be executed physician and the burial-transit	dicai Exa	resulting in death) Last	Due to (or as a consec	quence of):		-				
death certifications at for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes  No 9 Unknown	23c. If yes, outcome of pregn 1 Live birth 2 Feta 4 Pregnant at time of o	aldeath 3	Ectopic pregr Other (specif			23d. Date Mont	of delivery h Day Y	Year
es that igned by be deta	by Ph	Part II. Other significant conditions of	contributing to death but not res	sulting in the u	nderlying caus	e given in Part I.	23e. Did tob	acco use contrib	oute to the cause of d	eath?
law requires t as been signed 2 should be							1 <b>⊻</b> Ye	s 2□No 3	Probably 4 🗆 U	Inknown
The The	Completed						24a. Was ar autops perform 1 Yes 2	y pri ned? de	ere autopsy findings a for to completion of ca ath? Yes 2 No	available ause of
Sec.	o Be	25. Was case referred to medical examiner?  1 Yes No	Hospital: 1 ☐ Inpatient 2 ☐	ER/Outpatier	nt 3 DOA	Othor	eath (Check only one Home 5 Reside		(Canaiki)	
ding Phys After this funeral dia	-	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time o		Injury at Work?	28d. Describe ho			
To the Hospitel or Attending Phy within 24 hours after death. To the Funerel Director; After this completely filled in by the funeral of	Certification:	Natural 5 Pending 2 Accident investigation 3 Suicide 6 Could not b 4 Homicide determined	9 390 Place of Injury - At h	ome, farm, st	М	1 Yes 2 No	28f. Location (Str City or Town		r or Rural Route Numi	ber,
To the Hospitel o within 24 hours aft To the Funerel Di completely filled in	edical Cer	(Check only 2 Medical Exar	nysician: To the best of my kniner: On the basis of examina	owledge, deat						)
To the Ho within 24 To the Fu completel	Med	29b. Signature and title of certifier	and manner stated.	lan.	29c. L	cense number	29	7//0/	(Month, Day, Year)	
<b>\$</b> *****		30. Name and address of person who	completed cause of death (Ite	m 23a) (Type.	Print)	-01 11		/ (	11100	
5		KIOUMBREE YS	zdani, MD, 255	5 S	Noman S	13. Kd., N	Hunting	town, Mi	20639	
St	ate	31. Date filed (Month, Day, Year)	32. Registra s Sign	ature	hour	W. a				

DHMH 17 Rev 1/2001

Physicia		1 - For MEND#20 boar Fh7/1 State AMEND#12, 20 aper 1. Decedent's Name (First, Middle, La.		W,IVOLO	Cei	tificat	e of L	Death		2. Date of De	-	. U	UU	ل ک	1 4
	an		•							Month	Da		Year	3. Time o	
/Medic		William Michael Ly 4a. Facility Name (If not institution, give		25)		45 0%	Taura	Landina of	Death	July 2		006		10:45	a M
Examin	er		Street Znd numbe	51/		4D. City,	TOWN, OF	Location of	Death		4C.	. County	of Death		
uneral		Holy Cross Hospital 5. Social Security Number 6. S	9x 7.	Age (In yrs. la	ast birthday)	Silv If Under	ver Sp	ring If Under 24	4 Hrs.	8. Date of Bir		Montg	omery	lana (Ctata	C
irector		1	M 2□F	90	Yrs.	Months		Hours	Min.	(Month, Da	y, Year)	ĺ,	Coun		_
	Ì	579-05-1005 Usual Residence of Decedent								Aug. 3,	1915		Massac	husett	5
ehow ad at		10a. State 10b. County		10c. City	, Town or Lo	cation							1	Od. Inside C	ity Limits
od other than "natural; or iteme 23a or 28a-f ehov event, the Medical Exeminer must be notified at	Ş	Maryland Montgomer	v	Si	lver Sp	ring								1 🗌 Yes	2 <b>x</b> No
or 28	Director	10e. Street and Number	/		TVOL OF	10f. Zip	Code			T	10g. Cit	izen of V	What Coun	try?	
23a	<u>a</u>	3116 Gracefield Roa	d, Apt. TO	2			20904					USA			
Ē	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.S		Vas Deced	dent of His	spanic Origi	n? (Spec	cify Yes or No		14. Race	e - Americ	an Indian,	
and a		1 ☐ Never Married 2 Married	Armed Force 1 ☐¥es 2[	s? ⊐N∘1938-	-1968			n, Mexican,	Puerto F	Rican, etc.)		Blac	k, White,	etc.	
Exa	by	3 Widowed 4 Divorced	If Yes, Give Year or Date		75	☐ Yes	2L <b>★</b> No	Specify:				Specif	hite		
lical	Completed	15. Decedent's Ed (Specify only highest gra	ucation		16a. Deced	ent's Usua	al Occupa	tion			16b. Ki	ind of Bu	isiness/Ind	lustry	
Mes	ğ	Elementary/Secondary (0-12)	College (1-4d	or 5+)	life. E	OO NOT us	nk done di se retired)	uring most o	or workin	g					
2	్		3		Admi:	nistra	ator					U.S.	Gover	nment	
Ven	Be (	17. Father's Name (First, Middle, Last)						18. Mother's	s Name	(First, Middle,	Maiden				
2	၉	Michael Joseph Lyons					ĺ	Eliza	abeth	Walsh					
umatic ev		19a. Informant's Name/Relationship (7	ype, Print)		19b. Mailin	g Address	(Street a	nd Number	or Rural	Route Numbe	er, City o	r Town,	State, Zip	Code)	
at T		Rita W. Lvons/ Wife													
or other traumatic		20a. Method of Disposition			ace of Dispos	sition (ivan	ne or		Da	IO2, Sil	20c. Lo	cation -	City or To	wn, State	
any injury or o		1 ☑ Burial 2 ☐ € remation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		le	metery, crem ngton N	-		1	Augus	st 14					
를 a	Ì	21. Signature of Funeral Service Licen		121111						<del>24</del> 2006		gton,	Virg	inia	
5 8		) ( ) which is	2 ( , 0 ,							al Home					
	-	23a. Part1. Enter the disease, or composhock, or heart failure. List only	lications that caus	ed the death						Silver S		, MD	20901	Approximat	
ים יים יים יים יים יים יים יים יים יים	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	c	as a conseque											
- 97	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcom 1 □ Live birth 4 □ Pregnant	2 Fetal o	death 3□l	Ectopic pre					2	3d. Date Mon	of deliver		/ear
o detached	S	9 Unknown	9□ Unknown				,,				4				
1	2	Part II. Other significant conditions co	ntributing to death	but not result	ting in the un	derlying ca	ause giver	in Part I.		23e. Did to	bacco u	se contri	bute to the	cause of d	eath?
		Atrial Fibrillation, (	`actmintoc	tinal D	l and inc	T.T.		_		1 🗆 Y	es 25	₹No :	3 ☐ Proba	biy 4 □U	Inknown
1	ete	The Box Paris Control of the Control	MOCIOTICOS	CHICL D	<del>госинцу,</del>	THERID	prysis								
	Completed								_	24a. Was	sv	24b. W	ere autop:	sy findings a pletion of ca	available ause of
<b>3</b> 0	3									1 Yes	med? 2€ No		eath? □ Yes 2	!□ No	
									Death /	Check only o	70				
octor	e n	25. Was case referred to medical examiner?	La Sa Is									□ Other	r (Specific)		
long le	o ne	examiner? 1 ☐ Yes 2 ☐ No	Hospital: 1 🙀 Inpa		R/Outpatient			4 🗆 Nursi	ng Home	9 5 ☐ Resid	ence 6		(Spacify)		
6	o ne	examiner? 1 ☐ Yes 2 ☐ No 27. Manner of Death	Hospital: 1 🙀 Inpa 28a. Date of In (Month, D	jury 2	R/Outpatient 28b. Time of Injury			4 🗆 Nursi		e 5 Resid					
	o ne	examiner? 1 ☐ Yes 2 ☐ No  27. Manner of Death  y ☐ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of In	jury 2	28b. Time of		Bc. Injury a Work?	4 🗆 Nursi	28						
the funeral director	0 00	examiner? 1 □ Yes 2 □ No  27. Manner of Death  fx☑ Natural 5 □ Pending	28a. Date of In (Month, D	jury 2 Pay Year)	28b. Time of Injury	M 28	3c. Injury a Work? 1 □ Ye	at Nursi	28		ow injury	occurre	d	Route Numb	ber,
ely filled in by the funeral director.	Certification: 10 Be	examiner?  1 □ Yes 2 □ No  27. Manner of Death  1 □ Natural 5 □ Pending  2 □ Accident investigation  3 □ Suicide 6 □ Could not be	28a. Date of In (Month, D	jury lay Year)  njury - At hometic. (Specify)  it of my know of examination	28b. Time of Injury	M 28	Bc. Injury a Work? 1 \( \text{Ye} \)	at as 2 No	28	d. Describe h	treet and	occurre	r or Rural		
ely filled in by the funeral director.	legical Certification: 10 be	examiner?  1	28a. Date of In (Month, D 28e. Place of In building, d sician: To the besiner: On the basis	jury lay Year)  njury - At hometic. (Specify)  it of my know of examination	28b. Time of Injury	M 28 M occurred a estigation,	Bc. Injury a Work? 1 \( \text{Ye} \)	at at PNOISI	28	d. Describe h  If. Location (S  City or Tow  If due to the company of the time, company of th	ow injury treet and n, State) ause(s) ate and	Number	r or Rural	ted. he cause(s)	
the funeral director.	legical Certification: 10 be	examiner?  1	28a. Date of In (Month, D 28e. Place of In building, d sician: To the besiner: On the basis	jury lay Year)  njury - At hometic. (Specify)  It of my know of examination	28b. Time of Injury	M 28 M occurred a estigation, 29c.	Bc. Injury a Work? 1  Ye office	at at and phonon, death on	28	d. Describe h  If. Location (S  City or Tow  If due to the company of the time, company of th	treet and n, State) ause(s) a ate and	and man place, ar	r or Rural inner as stained due to t	ted. he cause(s)	
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tor: After this certifithe funeral director.	Medical Certification: 10 Be	examiner?  1	28a. Date of It building, of the basis and manner s	inity Year)  ay Year)  anity - At homotocy (Specify)  at of my know of examination stated.	28b. Time of Injury  ne, farm, street  ledge, death on and/or inve	M 28 M 28 M 28 M 29 M 29 M 29 M 29 M 29	Bc. Injury 2 Work?  1 Ye office  at the time in my opin License in DD2364	at as 2 No	28 28 place, an occurred	d. Describe h  If. Location (S  City or Tow  If due to the company of the time, company of th	treet and n, State) ause(s) a ate and	and man place, ar	r or Rural inner as stall due to t	ted. he cause(s)	

			1 - For State Registrar	State of N	faryland / Depa <i>Ce</i>	artment of F <i>rtificate of</i>	lealth and M <i>Death</i>		jiene 2 (	006	2314
	Physic		Decedent's Name (First, M. Camille Mon	ddle, Last) tgomery Lund	.ell			2. Date of Dea Month July 2,		Year	3. Time of Death
	/Medi Exami		4a. Facility Name (If not institu			4b. City, Town, o	r Location of Death	001) 2,	4c. County	of Death	2100
			Suburban Hos	pital		Bethe	sda		Mon	tgome	ry
	Funeral Director		5. Social Security Number 548-42-3995	1□M 2⊠F	ge (In yrs. last birthday) 87 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day July 18	,1918	9. Birthp Court Aus	lace (State or Foreign htry) tralia
	and		Usual Residence of Decedent  10a. State 10b. Cou		10c. City, Town or Lo	ocation					Od Inside City I in its
	Maryl feho	o		tgomery	Bethes					1	0d. Inside City Limits  1X□ Yes 2 □ No
	r 28a	rec	10e. Street and Number	egomery	Beenes	10f. Zip Code		1	0g. Citizen of \	What Coun	
	th with	aiD	4925 Battery	Lane #606		20814	4			SA	.,.
36	be filed within 72 hours after death with the Maryland hal Hygiene. Id other than "nature!, or items 23a or 28a-f show event, the Medical Examinar must be notified at	by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ N 3 ☐ Widowed 4 ☐ Nover	If Yos Give	? ]No	Was Decedent of H If Yes, specify Cuba 1 Yes 2 No	lispanic Origin? (Spe an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		e - Americ ck, White,	
8	2 hou		15. Dece	tent's Education		dent's Usual Occup	ation		16b. Kind of Bu	WII.	
215	hin 7:	Completed	(Specify only hig Elementary/Secondary (0-1)	hest grade completed)	(Give	kind of work done of DO NOT use retired	during most of working	ng	TOD. KING OF BO	1211162241110	lustry
2	filed will Hygien other th	Con		5+	Teach	er			Ec	lucat	ion
Maryland 21215-0036	2 should be fill and Mental H is marked off raumatic even	To Be	17. Father's Name (First, Midd William Patr:	ick Montgomer	у		18. Mother's Name Honorah I		Maiden Sumam	10)	
lan	s 1 and 2 should f Health and Mer item 27 is marks other traumatic	·	19a. Informant's Name/Relation	, , , , , ,	- Y	ng Address (Street	and Number or Rura	l Route Number	City or Town,	State, Zip	Code)
	r Health tem 27 other tr		Honora Lundel	l Precourt/Da	- The same of the		t.,NW.,Was				
Baltimore,	Page nent o ant: If ury or			on 3 □Removal from State (Specify)	20b. Place of Dispo cemetery, crer Gate of H	natory or other plac	:e)	6,2006	20c. Location · Silver		
Balt	permit. Depertr Imports eny inje		21. Signature of Furneral Servi	ce Licensee Delle			ss of Facility DeV				20007
			23a. Part1. Enter the disease, shock, of heart failure. L	or complications that cause ist only one cause on each	d the death. Do not entiline.	er the mode of dyin	g, such as cardiac o	r respiratory arre	est,		Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	a	ALM(_(	olits					Onset and Death
	Examiner		Sequentially list conditions	(	Clostwali	UMOIT	xill co	Pitis			50
	sit ad	Examiner	Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as	s a consequence of):						
_	xecut	хаш	that initiated events resulting in death) Last	c Due to (or as	a consequence of);						
68760,	ificate be executed g physician end as the burial-transit	aiE			3						
	± 0 a	ledical		u							
P.O. Box	The law requires that the death certificate has been signed by the ettending page 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 mopths? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		2 Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mor	of deliver	y Day Year
	s that ned by		Part II. Other significant cond	itions contributing to death	out not resulting in the un	nderlying cause give	en in Part I.	23e. Did tob	acco use contr	ibute to the	a cause of death?
rds	v require been sig should b	ed b	- Chro	MIC OBST	ipation			1 ☐ Ye	s 20No	3 🗌 Proba	bly 4 □Unknown
Division of Vital Records,	The law recate has be page 2 sho	Completed by						24a. Was an autopsy perform	ed? d	rior to com eath?	sy findings available pletion of cause of
/ita	ilcian: Th certificate rector, pag	Bec	25. Was case referred to medi examiner?	cal			26. Place of Death			☐ Yes 2	No No
of \	shyste this o	၉	1 ☐ Yes 2 No	A	ent 2 ER/Outpatient		4   Nursing Hom	ne 5 ☐ Resider	nce 6 ☐Othe	r (Specify)	
ion	auth. or: After or: After	ation;	27. Manner of Death Natural 5 Peni Control Peni	28a. Dat o Injuding (Month, Dastigation	ury 28b. Time of Injury	28c. Injury Work M 1 ☐ Y	at 2i ? ′es 2 □No	8d. Describe how	w injury occurre	ed .	
DİVİ	s after de s after de al Directo ed in by ti	Certification;	3 ☐ Suicide 6 ☐ Cou 4 ☐ Homicide dete	rmined 286. Place of In	jury - At home, farm, stre tc. <i>(Specify)</i>	eet, factory, office	2	8f. Location (Stro City or Town,	eet and Numbe State)	or Or Rural	Route Number,
	To the Hospital or Attending Physician: within 42 hours after death.  To the Funeral Director: After this certified, completely filled in by the funeral director, completely filled in by the funeral director.	Medical	29a. Certifier 1 Certific (Check only one) 1 Medic	ring Physician: To the best al Examiner: On the basis of and manner st	a examination and/or inv	occurred at the tim estigation, in my op	e, date and place, ar inion, death occurre	nd due to the car d at the time, da	use(s) and mar te and place, a	nner as sta nd due to t	ted. he cause(s)
	Withi Comp	Σ	29b. Signature and title of certif	fier	/	29c. License	number	29	d. Date signed	(Month, D.	ay, Year)
)	15		rvinu	ellonal	MYOU	MD	54720		7/2/0	00	
			30. Name and address of person								
	Sta	te.	Melissa L. Mea 31. Date filed (Month, Day, Yea		- 1- O' - 1	140	etown Rd.	Betheso	da, MD	2081	4
	Registr		JUL 0	7 2006	ars Signature	de la					

DHMH 17 Rev 1/2001

Comille M. Londell July 2, 2006 show

			1 - For State Registrar	State of Mary		artment of Hertificate of L		ental Hygier	211116	23149
	Physici		Decedent's Name (First, Middle, La     Loretta	st) Carney	LaNeve			2. Date of Death Monthy	Pay Year	3. Time of Death
	/Medic Examin Funeral Director		4a. Facility Name (If not institution, given the second of	e street and number)	MOUS o yrs. (list birthday) Yrs.	4b. City, Town, or  If Under 1 Year  Months Days	berlay	8. Date of Birth Month, Day, 19 Jun 5, 19	4c. County of Dea MLGI 23	th Children (State or Foreign
	yland		Usual Residence of Decedent  10a. State 10b. County		c. City, Town or Lo					10d. Inside City Limits
	the Mar	Director	MD Allega	ny	Cum	perland				1 X Yes 2 □ No
	th with	al Dir	212 Cumberland	Street		10f. Zip Code	21502	10g. (	Citizen of What Co	ountry?
aryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hyglene. If Item 27 is marked other then "natural; or items 23e or 28e-f show or other traumatic event, it a Medical Examinar result be notified at	d by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		□Yes 2ĂNo	spanic Origin? (Spec n, Mexican, Puerto R Specify:	ify Yes or No- ican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
215-	hin 72 les.	Completed	15. Decedent's En (Specify only highest gra Elementary/Secondary (0-12)		(Give	lent's Usual Occupat kind of work done du 20 NOT use retired)	uring most of working	g 16b.	Kind of Business/	Industry
d 21	filed wit Hygien other th	Con	12 17. Father's Name (First, Middle, Last,		sales		18. Mother's Name (		welry Co.	
ylan	2 should be and Mental le marked o aumatic eve	To Be	George L. Carn				Loretta	(Knieriem)	Carney	
≥	and 2 sho ealth and n 27 le m		19a. Informant's Name/Relationship ( Patricia Mullaney	Type, Print) daught	er 25 N	g Address (Street ar Martz Lane	nd Number or Rural	Route Number, City LaVale	or Town, State, 2	D 21502
altimore,	Pages 1 and of Heren	3	20a. Method of Disposition 1 Surial 2 Cremation 3	Removal from State	0b. Place of Dispo	sition (Name of patery or other place)	) Da		Location - City or	
Baltin	permit. Pages 1 a Department of Hea Important: if Item any injury or othe ance.		4 □Donation 5 □Other (Specification of Funeral Service Lie of				funeral Hor		umberlan	d MD
	40 E 6 0		23a. Part I for the disease, or com	plications that caused the		108 Virgi	inia Avenue:	Cumberland	d, MD 2150	Approximate
	Physician /Medical Examiner	_	Immediate Cause (Final disease or condition resulting in death)	a. Left  Due to (or as a col	Lower nsequence of):	LOBE	PNEUN	ONIA	îse.	Interval Between Onset and Death 8 days
3,0978	icate be executed physician and the burial-transit	dicai Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conduct of the co						
O. Box 6	tha death certifi by the attending ached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	23c. If yes, outcome of pn 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
ras, P	es the	þ	Part II. Other significant conditions of	BREAST	t resulting in the un		in Part I.		_	the cause of death?
_	The law ate has b paga 2 sl	e Completed	25. Was case referred to medical					24a. Was an autopsy performed?	prior to o death?	opsy findings available ompletion of cause of 2 No
	Physicien: this certific ral director,	<u>م</u>	examiner?	Hospital: 1 Manpatient	2 ☐ ER/Outpatient	3□ DOA Other:	26. Place of Death ( 4 ☐ Nursing Home	Check only one 5 ☐ Residence	6 □Other (Spec	nfy)
0	th. After t		27. Manner of Death  1 Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Yea	28b. Time of Injury	28c. Injury a Work? M 1 ☐ Ye		d. Describe how inju		,,
DIVISION	ST. F. S. S. S. S. S. S. S. S. S. S. S. S. S.	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - A building, etc. (Sp.	pecify)	et, factory, office	281	f. Location (Street a City or Town, Stat	e)	
	te Hosp 124 hou te Fune bletaly fi	edical	29a. Certifier (Check only one)  Certifying Ph 2 ☐ Medical Exam	ysician: To the best of my iner: On the basis of exam and manner stated.	knowledge, death mination and/or invi	occurred at the time, estigation, in my opin	date and place, and nion, death occurred	d due to the cause(s at the time, date ar	s) and manner as a d place, and due	stated. to the cause(s)
	To the comp	W	29b. Signature and title of certifier	- 0		29c. License n	w		ate signed (Month)	
	10	-	30 Name and address of person who o	completed cause of death	(Item 23a) (Type. F	D237	114	JUL	y 17,	2006
	1		1 ).	soud mb, 9	112 SETON	U DRIVE,	CumBER	RLAND MI	TRYLAND	21502
	Stat Registra	~	JUI 2 1 21	32. Pagistrar's S	ignature	- 10				

DHMH 17 Rev 1/2001

			1 - For State AMEND#18perINF	State of Mar 7/11/06,BM,Mo		artmer <i>rtifica</i> :			nd Me		gien Reg. No	ZUUD	23	150
	Dhusisi		1. Decedent's Name (First, Middle, La	st)					2	2. Date of De. Month	ath Da	y Year	3. Time o	f Death
	Physici /Medio		Maude G. McCl	ung						July	9,	2006	6:15	рм
	Examir		4a. Facility Name (If not institution, given	e street and number)		4b. City	, Town, or	Location of	Death		40	. County of Death		
			Montgomery Hosp				ckvi						gomery	
	Funeral		5. Social Security Number 6. S	Sex 7.Age(a I□M 2√⊋F	In yrs. last birthday,	Months Months	r 1 Year Days	Hours 24	4 Hrs. 8	B. Date of Birt (Month, Da	th y, Year,	9. Birthr	lace (State	or Foreign
	Director		217-22-7264	-X-	95 Yrs.				J	uly 27	7, 1	910 West	Virgi	nia
	and w		Usual Residence of Decedent  10a. State 10b. County	1	0c. City, Town or L	ocation	<del></del>						0d. Inside C	ity Limits
	Aaryl • • ho	ŏ			•									2-€ No
	28a-	ect	Maryland Montgo	nery	Olne		p Code				10a Ci	tizen of What Cour	star?	
	with	ā	17737 Overwood	Drive		101. 21	p 0000	20832	2	Ì	rog. Ci	USA	iuy:	
	72 hours after death with the Maryland netural', or Iteme 23a or 28a-f ehow dical Examinat must be notilled at	Funeral Director	11. Marital Status	12. Was Decedent Eve	er in U.S. 13.	Was Dece	ident of His			fy Yes or No	_ ]	14. Race - Americ	an Indian	
10	fer o	F.	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No				n, Mexican, I	Puerto Ri	fy Yes or No- can, etc.)		Black, White,		
33	urs a	þ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 🗌 Yes	2 <b>፭</b> No	Specify:				Specify: Whi	te	
21215-0036	2 ho	Completed	15. Decedent's E		16a. Dece	dent's Usu	al Occupa	ition	- f t-t		16b. H	(ind of Business/In	dustry	
215	within 7 ene. than *r	ple	(Specify only highest gri	College (1-4or 5+)	life.	DO NOT	use retired)	uring most o	or working					
21	filed withi Hygiene. other ther	Son	6		Но	memak	er					Own Ho	ne 	
pu	al Hy al Hy al Oth	Be (	17. Father's Name (First, Middle, Last	)				18. Mother	s Name (	şüe Middle Şüe Br	yaide Yan	Sumame)		
Va	should be nd Mental marked o	2	Joseph Crane					Nancy	7_A_	Bryant		-		
Maryland	C D b b		19a. Informant's Name/Relationship (		19b. Maili	ng Addres	s (Street a	nd Number	or Rural I	Route Numbe	or, City	or Town, State, Zip	Code)	
	1 and 2 sl Health and tem 27 is r		Nancy A. Fina, D.	augiicei	1//3	7 000	ET WOOK	A DITV	/e, c	They,	Mar	yland 20		
Baltimore,	permit. Pages 1 an Depertment of Heal Important: If Item 2 eny injury or other once.		20a. Method of Disposition  1 Burial 2 Cremation 3		20b. Place of Disponentary, cre	osition (Na matory or	me of other place	9)   75	Dai 5.7		20c. L	ocation - City or To	wn, State	
Ĕ	Pag nent ant: I		4 Donation 5 Other (Special	Entombment	Wallace Mer	morial	Mauso	leum	fuly : 200		Cli	ntonville	. WV	
alt	Depertr Depertr Import eny inj		21. Signature of Funeral Service Lice	1500								me Inc.		
0	89 = 9		Will Efor	wift	5	00 Un	iver	sity E	31vd,	W, Si	lve	r Spring	MD 2	0901
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the	e death. Do not en	ter the mo	de of dying	, such as ca	ardiac or i	espiratory ar	rest,		Approximation	te tween
	Physician		Immediate Cause (Final disease or condition	a Dementia									Onset and	
	/Medical		resulting in death)	Due to (or as a c	onsequence of):			·						
	Examiner		Sequentially list conditions	Debility										
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a c	onsequence of):									
	ate be executed only sicien and the burial-transit	Examiner	that initiated events	c										
o,	e exe		resulting in death) Last	Due to (or as a c	onsequence of):									
8760,	ate b hysic	ca		d										
9	that the death certificate be executed ed by the attending physicien and detached for use es the burial-transit	Physician/Medical	IF FEMALE:											-
Вох	th ce	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of p 1 ☐ Live birth 2 [		⊒Ectopic p	regnancy					23d. Date of delive	•	
-	e death he atten hed for u	sici	1 Yes 2 No	4 Pregnant at tim 9 Unknown	e of death 5	Other (s	pecify)					Month	Day	Year
P.O.	at the	Phy					-			T				
	es De d	þ	Part II. Dther significant conditions	contributing to death but r	ot resulting in the u	inderlying (	cause give	n in Part I.				use contribute to th		
Records,	w requir been s should	Completed								1 U Y	es 2	K∏No 3∏Prob	ably 4 ∐l	Unknown
ပို	e law r has be ge 2 sh	ple								24a. Was autop		24b. Were auto	psy findings	available
æ	The effe	ě								perfor	rmed?		npletion of a 2□ No	4430 01
Vital	Physician: this certific ral director,	Be (	25. Was case referred to medical examiner?					26. Place o	of Death (	Check only o				
of V	Physic this ce al dire	2	1 ☐ Yes 2 ☐ No	Hospital: 1   Inpatient	2 ER/Outpatie	nt 3 D	OA Othe	r: 4 🗌 Nurs	sing Home	5 ☐ Resid	lence	6 <b>☑Q</b> ther (Specify	Hospi	ce
0	o = a		27. Manner of Death  1√√Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y	28b. Time o	if :	28c. Injury Work			d. Describe h				
<u>Ö</u>	Attending r death. ector: After oy the fune	atic	2 Accident investigatio	n		М		es 2 No	0					
Division	or Att	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		- At home, farm, st Specify)	reet, factor	y, office		28	f. Location (S City or Ton	treet ar	nd Number or Rura	Route Num	ber,
	rs eff											,		
	Hospital	cai	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exa	nysician: To the best of miner: On the basis of ex	ny knowledge, deat	h occurred	at the time	e, date and p	place, an	d due to the d	ause(s	) and manner as st	ated.	
	To the Hospital or Attend within 24 hours effer death To the Funerel Director: completely filled in by the	Medical	Uney	and manner stated	I.				. 50001180					71
	To the within 2 To the complet	2	29b. Signature and tine of certifier		440	29	c. License			1	∠9d. Da	te signed (Month,		06
	D		17/	$\sim$	.417		D35	5635				July 1	10, 20	06.
	-		30. Name and address of person tho	completed cause of deat	h (Item 23a) (Type,	Print)								
			Joseph Kaplan,		ıncaster			, Rock	vill	e, MD	208	55		
	Sta Registr		31. Date filed (Month, Day, Year)  JUL 10 2	32 Registrar's	Signature	whi								

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			1 - State Registrar AVEN		-1)perMD		nd/Depa MW,Mc©e			th		Reg. No.	006	23   5
	Physici /Medic		1. Decedent's Name (F Sharie Mc		st)						2. Date of Dea	Day Zo	Year	3. Time of Death
	Examir		4a. Facility Name (If no	et institution, give	street and nu	~ —			wn, or Locati	on of Death		4c. Cour	nty of Death	
	Funeral Director		5. Social Security Numb 220-48-9609	1	ex □ M 2 🛣 F	7. Age (In yrs 56	s. last birthday) Yrs.	If Under 1 Months E	Year If Uno Days Hou	der 24 Hrs. rs Min.	8. Date of Birt (Month, Da Sept. 13,	1949	9. Birthp Cour Missol	lace (State or Foreign htry). LTI
-	/land ow		Usual Residence of De- 10a. State 10	ocedent Ob. County		10c. C	City, Town or Lo	cation					1	0d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show if must be notified at	ctor	Maryland Pr	ince Geor	ge's		Capito	l Height	s					1 ☐ Yes 2X No
	or 28	Director	10e. Street and Numbe		4004			10f. Zip Co				10g. Citizen o	of What Coun	ntry?
	eath v	erai	1911 Brooks	s Drive,		edent Ever in	116 12		0743	Osigina (Cana	W. Von er blo	14 B	USA ace · Americ	an Indian
036	5 Z Z	by Funeral	1 Never Married 3 Widowed 4		Armed For 1 Pes If Yes, Gir Year or D	orces? 2 🖾 No ve		if Yes, specify			city Yes or No- Rican, etc.)		lack, White,	etc.
5-0	72 ho	eted	15. (Specify o	i. Decedent's Ed only highest gra	lucation de completed)		16a. Dece	dent's Usual (	occupation	nost of workin	g	16b. Kind of	Business/Inc	dustry
121	within ene. then	Completed	Elementary/Seconda 12	ary (0-12)	College (	1-4or 5+)	life.	<i>00 NOT</i> use . <b>Police</b>				ī	aw Enfo	orcement.
д 2	e filed Il Hygi other	Be C	17. Father's Name (Firs	st, Middle, Last)						other's Name	(First, Middle,			ACGIRETE.
<u> </u>	Menta Menta arked	To	Wilber Snow							Margere	t Melbor	n		
Mar	d 2 sh th and 7 lam traum		19a. Informant's Name. William McC.								Route Numbe	-	•	
ē	s 1 and f Heal		20a. Method of Disposit				Place of Dispo cemetery, crer	sition (Name	of	Da		i hts. N 20c. Location		
<u> </u>	Page Tient o		1 ☐ Burial 2 🖾 C 4 ☐ Donation 5 ☐			State Met	ropolitar			July 2006		Alexandr	da Wa	winia
Baltimore, Maryland 21215-0036	permit. Depertiment important any inj		21. Signatur o Funera	al Service Licen	Colo		<b>F</b> i	name and ancis J O Unive	ddress of Fa Collin rsity B	cility Timera	al Home Silver S	Tnc.		*
	Physician		23a. Part 1. Enter the d shock, or heart fai Immediate Cause (Fina disease or condition	allure. List only	ications that cone cause on e		ath. Do not ent Spirat	tion		as cardiac or nonia	respiratory ari	rest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)		Due to	(or as a conse	quence of):	· · · ·						DAYS
		Jer	Samential y list conditi if any, leading to immed cause. Enter Underlyin Cause (Disease or injur	ions idiate	b. Due to	(or as a conse	31 1 CO	1014			_			
ARIE. 68760,	tilicate be executed g physician and as the burial-transit	edicai Examiner	cause. Enter Underlyin Cause (Disease or injur that initiated events resulting in death) Last		c	(or as a conse	quence of);							
O. Box	he death cert the ettendin thed for use	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pre in the past 12 mor 1 ☐ Yes 2 ☑ More 9 ☐ Unknown	nths?		ointh 2 □ Fet nant at time of	al death 3	lEctopic pregi Other (speci					ate of deliver	ry Day Year
CEV rds, F	quires tha in signed uld be del	ed by P	Part II. Other significan	nt conditions co	ontributing to de	eath but not re	sulting in the ur	nderlying caus	e given in Pa	art I.		bacco use co es 2 □ No	ntribute to the	e cause of death?
ACCUNEY Vital Records, P.	iclan: The law re certificete hes bee rector, page 2 sho	Complete									24a. Was a autops perform	med?	prior to con death?	psy findings available apletion of cause of
X X X	siclan certifi rector	Be	25. Was case referred to examiner?	-	Hospital:	/			Other		Check only or			
A Division of	Attanding Physician: The lai si death. ector: After this certificate hes by the funeral director, page 2	tion; To	1 Yes 2 No  27. Manner of Death 1 Natural 5 2 Accident	i ☐ Pending investigation	28a. Date (Mont	npatient 2 of Injury th, Day Year)	28b. Time of Injury		Injury at Work?	28	e 5 Reside			)
Divisi	Att	Certification;		Could not be determined	28e. Place	of Injury - At h	nome, farm, stre ify)	eet, factory, of			If Location (Si City or Town	treet and Num n, State)	nber or Rural	Route Number,
	To the Hospitel or within 24 hours afte To the Funeral Dis completely filled in	Medical	29a. Certifier 1 (Check only 2 one)	Certifying Phy Medical Exam	ILLEL: OU IVE D	best of my kn asis of examin ner stated.	owledge, death ation and/or inv	occurred at t restigation, in	he time, date my opinion, d	and place, and death occurred	d due to the c	ause(s) and n ate and place	nanner as sta , and due to	ated. the cause(s)
	To 1 To 1	Σ	29b. Signature and title	of certifier	11,10.0		,	29c. Li	cense numbe			9d. Date sign		
	4	Î,	30. Name and address	MID who a	MURCA,			(Print)	P-17	610		TUNE	20, 2	006
2	1		MURTARA K	ADMI WE	14. K	INTE H	OLD ITAL	_	CAYON	ALEN	ue B	ALTIM	DEE N	ND 21329_
	Sta Registr		31. Date filed (Month, D	Day Year)	2008 32.	oistrar's Sign	ature A	media.					,	41

State of Maryland / Department of Health and Mental Hygiene [] [] [ For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death 3. Time of Death **Physician** July Kathleen M. McVay 2006 4:50 a м /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Jan. 13, 1 Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1 □ M 2 🕅 F 57 Yrs. 038-30-4740 Director 1949 Rhode Island Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10a. State 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at Anne Arundel 1 ☐ Yes 2X No MD Director Arnold 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ö 21012 USA 1302 Bonito Court items 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 Never Married 2 Married White 0 Baltimore, Maryland 21215-0036 1 Yes 2X No Specify: þ 3 ☐ Widowed 4 ☐ Divorced "natural', Completed 15. Decedent's Education 16a, Decedent's Usual Occupation 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. other than Elementary/Secondary (0-12) College (1-4or 5+) Registered Nurse Health other t 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be I and Mental John Goodwin Carol G. Young ဨ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Larry McVaY/Husband item 27 Arnold, MD 21012 1302 Bonito Court 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a, Method of Disposition Date 20c. Location - City or Town, State Department of the important: if its eny injury or of once. 1 Ø Burial 2 □ Cremation 3 □ Removal from State July 7, Maryland Veterans Cem. 4 □ Donation 5 □ Other (Specify) Crownsville, MD 2006 21. Signature of Funeral Servicy Lights 22. Name and Address of Facility
Barranco & Sons, P.A.
495 Gov. Ritchie Hwy. Severna Park Funeral H Severna Park, MD 21146 23a pant, Enter the disease, or cor plications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or fleart failure. List or by one cause on each line. Approximate Interval Between nset and Death I mediate Cause (Final Isease or condition resulting in death) Cancer Priysician /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infinediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine Hospital or Attending Physician: The law requires that the death certificate be executed physicien and s the burial-trans Due to (or as a consequence of): P.O. Box 68760 Physician/Medical attending IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown ğ Month Dav Year 4 Pregnant at time of death 5 Other (specify) ed by the a 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ۵ should b 1 Yes 2 🗆 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed2 certificate 2□ No 1 ☐ Yes 2 No director 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 2 2 ER/Outpatient 3 DOA this After the 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending death. investigation 1 Yes 2 No 2 Accident Director: 6 Could not be determined 3 🖺 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) hours after 4 ☐ Homicide within 24 hours a

To the Funeral E

completely filled i 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) the e 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 900 Bastgate Rd. Annapolis. Und Name and address of person who completed cause of death (Item 23a) (Type, Print)

STVAVA E. SEWNCHIM GO STUCIUT 2. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician Day Year Richard Warren McKeeby June 2006 /Medical 3:30 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Baltimore Washington Medical Center Glen Burnie Anne Arundel If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral**  Birthplace (State or Foreign Country) 1 XM 2 ☐ F Days Hours Director 81 149-18-2103 Nov. 5, 1924 Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 28a-f show 10d. Inside City Limits traumatic event, the Madical Examiner must be notified at MD Anne Arundel Director Severna Park 1 Yes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? ō 155 Downing Drive iteme 23a 21146 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 14. Race - American Indian, Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 XYes 2 No WWII If Yes, Give Year or Dates: Korea 1 ☐ Never Married 2 Married "natural", or 1 ☐ Yes 2 No Specify: Completed by White 3 ☐ Widowed 4 ☐ Divorced Specify. 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Electrical Engineer 5+ Northrop Gruman 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) 1 and 2 should be Health and Mental Warren McKeeby Ethel Merrick ٩ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2: Department of Health ar importent: If item 27 is any injury or other trauonce. Joan Helen McKeeby/Wife 155 Downing Drive, Severna Park, MD 21146 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State July 3, 1X Burial 2 ☐ Cremation 3 ☐ Removal from State MD Veterans Cemetery Crownsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 2006 21. Signature of Fyneral Service Licenses Barranco & Sons, P.A. Severna Park Fune 495 Gov. Ritchie Hwy, Severna Park, MD P.A. Severna Park Funeral Home Hwy, Severna Park, MD 21146 normy ( 2Ja. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a configuence of): **Physician** /Medical Examiner Small Donel Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed **burial-transit** Due to (or as a consequence of) Box 68760 Completed by Physician/Medical be detached for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4 Pregnant at time of death Month Day Year 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 25 No 24a. Was an has autopsy performed? Ca rs after death.
rai Director: After this certifuc... 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 2 Accident investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral L Hospitel Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signatur 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Bil ink 305 31. Date filed (Month, Day, Year) 32. egistrar's Signature State Registrar

Mchard McKeel

			1- FoAmend #5 Per FH G860 10 Maryland Dep	partment of Health and Mental Hy ertificate of Death	ygiene Reg. No. 2006 23154
Ė	Physici	an	1. Decedent's Name (First, Middle, Last)  MAR GUERITE  T	MADISU 2. Date of D  Month	
	/Medic Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			Anne Arundel Medical Center	Annapolis	Anne Arundel
	Funeral Director		5. Social Security Number 2.20-40-9018 1 M 2.54 F 93 Yrs.	// If Under 1 Year If Under 24 Hrs. 8. Date of B (Month, D 11-25-	(ay, Year) Country
	and		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	Location	10d. Inside City Limits
	Maryl	tor	MD Anne Arundel Annapo	olis	1 ☐ Yes 2 X No
	or 28c	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	eath w	Funerai	84 N. Old Mill Bottom Road  11. Marital Status 12. Was Decedent Ever in U.S. 13	21401  Was Decedent of Hispanic Origin? (Specify Yes or N	USA  14. Race - American Indian,
39	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hyglene. Importent: If Item 27 is marked other then "natural", or Iteme 23a or 28e-f show says injury or other treumatic event, the Madical Examination and once.	ğ	Armed Forces?  1 Never Married 2 Married 1 Yes 2 No Il Yes, Give Year or Dates:	. Was Decedent of Hispanic Origin? (Specify Yes or N If Yes, specify Cuban, Mexican, Puerlo Rican, etc.)  1 ☐ Yes	Black, White, etc.  Specify: White
Maryland 21215-0036	72 hou	Completed	15. Decedent's Education 16a. Dec (Specify only highest grade completed) (Giv	edent's Usual Occupation re kind of work done during most of working DO NOT use retired)	16b. Kind of Business/Industry
121	within ene. then	ompi	Elementary/Secondary (0-12) College (1-4or 5+) 4 Homes		Own Home
<u>م</u>	e filed at Hygi other	Be Co	17. Father's Name (First, Middle, Last)	18. Mother's Name (First, Middle	
<u>کاع</u>	Ould b Menta	<b>To</b>	Arthur George Thomas	Luta Deshayes	
Mar	id 2 sh ith and 27 is m treum			iling Address <i>(Street and Number or Rural Route Numl</i> 4 Gun Cap Court, Centrevi	
Jre,	of Hear		20a Method of Disposition 20b. Place of Disp		20c. Location - City or Town, State
Baltimore,	Page tment tent: It		4 Donation 5 Other (Specify) Metro Ci		Baltimore, MD
Bal	permit Deper Impor any in		21. Signature of Funeral Service Licenside	22. Name and Address of Facility Hardesty Funeral Home, 12 Ridgely Avenue, Anna	P.A. apolis, MD 21401
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart lailure. List only one cause on each line.  Immediate Cause (Final	nter the mode of dying, such as cardiac or respiratory	arrest, Approximate Interval Between Onset and Death
)	Physician /Medical		disease or condition resulting in death)  a. Due to (or as a consequence of):	<u> </u>	yeon
	Examiner		Sequentially list conditions, b		
	ted	Examiner	cause. Enter Underlying Cause (Disease or injury		
oʻ	execu en and rial-tra	Ехаг	that initiated events c. resulting in death) Last Due to (or as a consequence of):		
8760,	cate be executed physicien and the burial-transit	dical	d.		
9	eath certific attending p	√/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy		23d. Date of delivery
.O. Box	The law requires that the death certificate has been signed by the attending to agge 2 should be detached for use as	by Physiclan/Me	in the cast 12 months?	☐ Ectopic pregnancy ☐ Other (specify)	Month Day Year
<u>α</u>	s that gned b	oy Pt	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I. 23e. Did	tobacco use contribute to the cause of death?
Vital Records,	w requires t been signe should be	eted	armany row int	10	Yes 2 No 3 Probably Winknown
Rec	has b	Completed	,	24a. Wa. auto	s an 24b. Were autopsy findings available prior to completion of cause of death?
<u>ta</u>		a)	25. Was case referred to medical	1 ☐ Yes 26. Place of Death (Check only	2 No 1 Yes 2 No
Ž Z	Physician: r this certific ral director,	To B	examiner?  1 Yes 2 No  Hospital: 1 Xin atient 2 EP/Outpate	ent 3 DOA Other: 4 Nursing Home 5 Res	sidence 6 ☐ Other (Specify)
ouc	ding P. h. After t	tion:	27. Manner of Death  Thetural 5 Pending (Month, Day Year)  Accident investigation 24 Accident		how injury occurred
Division of	or Attenditer deat	Certification:	24 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, larm, s building, etc. (Specify)	street, factory, office 28I. Location	(Street and Number or Rural Route Number, own, State)
L	To the Hospitel or Attending F within 24 hours after death. To the Funeral Director; Atter completely filled in by the funer.	Medical Ce	29a. Certifier (Check only one)  Medical Examiner: On the basis of my knowledge, deal and manner stated and manner stated.	ath occurred at the time, date and place, and due to the investigation, in my opinion, death occurred at the time	e cause(s) and manner as stated. b, date and place, and due to the cause(s)
	ro the vithin 2 ro the complet	Med	one) and manner stated.  29b. Si inature and title of cythfier	29c. License number	29d, Qate signed (Month, Day, Year)
	->-0		Attive of offenda,	7 7 21438	July 05, 2006
			30. Name and address of person who completed cause of death (Item 23a) (Type	Print)	HANDER MARINA
	Sta	ate	31. Date liled (Month, Day, Year) 32. Magistrar's Signature	DETENSE MANNEY	11018
	Registi	rar	1111 0 7 2006	TOOK!	

			1 - For State Registrar	State	of Mary		ertificate of		d Mental H	lygien Reg. N	- / 11111	5 23	155
	-		Decedent's Name (First, Midd.	le, Last)					2. Date of	Death		3. Time o	of Death
	Physici		William Henry	McF1rov					July 1		ay Year 2006	2:33	ΔΜ
y"	/Medic Examin		4a. Facility Name (If not institutio		number)		4b. City, Town,	or Location of De			c. County of Dea		
П			7048 Basswood	Road			Frederi	ck		F	rederic	<	
	Funeral		5. Social Security Number	6. Sex 1 M 2 □ F		yrs. last birthda		r If Under 24 h			9. Bir	thplace (State	or Foreign
	Director		035-24-8244	163 M 2 □ F		69 Yrs.	Wild Hills Day	3 110013 11	June 8			le Isla	nd
	pu 💃		Usual Residence of Decedent  10a. State 10b. County	,	10	c. City, Town or	coation					10d. Inside C	No. Limite
	anyla shon	٦.				-							2 X No
	8a-f	Directo	Maryland Frede	rick	F	rederick				1			22110
	with t		10e. Street and Number				10f. Zip Code			10g. C	Citizen of What C	ountry?	
	s 23	al a	7048 Basswood		ecedent Ever	in II C	21703	Ulianania Osining	) (C===*-, V=====	USA	14. Race - Am	adam Indian	
215-0036	be filed within 72 hours after death with the Maryland Hygiene. Hygiene. da Hygiene. dother than "natural", or items 23a or 28a-f show other than "natural", or items 23a or 28a-f show evant, the Medical Exeminar must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 🌠 Mar  3 □ Widowed 4 □ Divorced	ried 1 X Ye	Forces? es 2 ☐ No Give or Dates: 19		. Was Decedent of If Yes, specify Cu 1 ☐ Yes 2 N	ıban, Mexican, Pι	uerto Rican, etc.)	NO-	Black, Whi		
Ş	2 ho	ted		nt's Education		16a. Dec	edent's Usual Occ			16b.	Kind of Business		
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21	giene giene	E O	2.3	05.109	5	State	Trooper			Law	Enforce	ement	
<u>8</u>	be filed ital Hygid of other	Be	17. Father's Name (First, Middle,	Last)				18. Mother's h	Name (First, Midd	dle, Maide	en Sumame)		
<u>a</u>	ould b		Thomas Francis 1	McElroy				Margar	et (NMN)	0 <b>'</b> L	oughlin		
Maryland	2 should be and Menta is marked aumatic ev	35	19a. Informant's Name/Relations	ship (Type, Print)		19b. Ma	ling Address (Stree					Zip Code)	
	s 1 and 2 should f Health and Men frem 27 is marke other traumatic		Alice Sarah Joh	ne McElro			Basswood	d Road,	Frederic	k, M	aryland	21703	
<u>S</u>	00		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	2 Domousl fr		Ob. Place of Disp	oosition (Name of ematory or other p		Date		Location - City or		
Ĕ	Pages nent of ant: If It ary or o		4 Donation 5 Other (S		R	ocky Ga	Veteran	s Cem. 7	/21/2006	F1:	intstone	, Maryl	and
Baltimore,	permit. Page Department Important: If any injury o		21. Signature of Juneral Service	Licensee			22. Name and Add						
10	80 E E 8	6 8	Kyan M	1. Blug	er	M00999	106 East	Church	Street,	Fred	erick, M	D 2170	
			23a. Part1. Enfor the disease, o shock, or heart failure. Lis	r complications the	at caused the	death. Do not e	nter the mode of d	ying, such as card	diac or respiratory	arrest,		Approxima Interval Be	te tween
	Physician		Immediate Cause (Final disease or condition		Ec	= aha	weak	(a)	ncer			Onset and	Death
	/Medical		resulting in death)	a	to (or as a co	insequence of	The					17m	MThA
П	Examiner		Process and the Boar are a Marine										
	n =	ner	if any, leading to immediate cause. Enter Underlying	Due	to (or as a co	nsequence of):							
	nd	Examln	Cause (Disease or injury that initiated events	c									
Ď,	be executed sician and burial-transit	Ä	resulting in death) Last	Due	to (or as a co	nsequence of):							
8/60	cate be executed physician and the burial-transit	dlcal		d					_				
9		Mec	IF FEMALE:										
ROX	the death certifi y the ettending ched for use as	Physician/Me	23b. Was decedent pregnant in the past 12 months?	1⊡Liv	outcome of project of project of the control of the	Fetal death 3	□Ectopic pregnan	су		ĺ	23d. Date of de Month		Year
	at the dea by the e	sici	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		egnant at time iknown	of death 5	Other (specify)	<del>-</del>		-	WIGHT	Day	1 641
J.	that the ed by detacl		Part II. Other significant conditi	one contribution t	a doath but a	at consisting in the	darbiina ana	usan in Dard I	22a Di	d toboood		- #	
Ś,	Se 15	þ	Partit. Other significant conditi	ons contributing to	o death out no	n resulting in the	underlying cause (	jiven in Part I.	1	☐ Yes :	use contribute to	robably 4 🗆	
Vital Records,	w require been si should t	Completed							- ''		ZLINO SKI		JIKIOWII
ဝ	law les b e 2 si	d d							_ 24a. W	topsy	24b. Were a prior to	utopsy findings completion of d	available cause of
=		Co							1 ☐ Yes	rformed?	death? lo 1 ☐ Yes	2 □ No	
/Ita	sician: The law certificete hes b irector, page 2 s	Be	25. Was case referred to medica examiner?						Death (Check onl	y one)			
6	Physician: r this certific ral director,	မ	1 ☐ Yes 2 🛣 No		□Inpatient	2 ER/Outpati	HIL 3L DOA		g Home 5ӁRe			cify)	
	ding P h. After funera	Ö	27. Manner of Death 1   Natural 5   Pendi	ng (M	ate of Injury fonth, Day Ye	ar) 28b. Time Injury	W	ork?	28d. Describ	e how inj	ury occurred		
<u> </u>	Attending ir death. ector: Afte by the fune	catl	2 Accident invest 3 Suicide 6 Could	igation not be				☐Yes 2☐No					
Division	or Attenater death	Certification:	4 Homicide determ	nined 206. Fig	ace of Injury - iilding, etc. (S	At home, farm, s pecify)	treet, factory, offic	9	28f. Location City or 1	n (Street a Го <mark>wп, S</mark> ta	and Number or R ite)	ural Route Num	ıber,
_	Hospital or At 24 hours after o Funeral Direc etely filled in by		20a Contiliar ATT 0	ne Dhysria'	4b - b								
	Hosi 24 ho Fun fely f	edical	29a. Certifier 1 Certifyi. (Check only 2 Medical	ng Physician: To Examiner: On the	e basis of exa	y knowledge, dea Imination and/or	ith occurred at the nvestigation, in my	time, date and pla opinion, death or	ace, and due to the courred at the time	ne cause( e, date a	s) and manner as nd place, and due	s stated. e to the cause(s	3)
	To the Hospital or A within 24 hours after To the Funeral Direction place of the Completely filled in by	Med	29b. Signature and title of certifie		nanner stated.	-	29c Lice	nse number		29d D	ate signed (Moni	th Day Yearl	
	F 18 F 8		1 2	~~		, m							
7	4					1 - 25 : =	D563	L4		Jul	y 17, 20	006	
	. 1		30. Name and address of person					Erec do-	iale Ma	l a	J 21701		
	Sta	to	Bindu George, 31. Date filed (Month, Day, Year	ии, 40-1 )	. Registrar's	Signature	on Dilve	, rreder	ick, Mar	yran	d 21701		
	Registr		JUL 24	2006	he sie	as Johns Signature							

220 Som  5. Social Security Nu 217-20-0 Usual Residence of 10a. State MD  10e. Street and Num 220 Som 11. Marital Status 1 Never Marrie 3X Widowed  (Specie	not institution, give steerville Ave. mber 6. Sex 754 1x Decedent 10b. County Allegany ber erville Ave.	Apt. 407	ge (In yrs. last birthda 74 Yrs.	Months Days		8. Date of Birt	Alleg	9. Birthplace (State or Forei
5. Social Security Nu 217-20-0 Usual Residence of 10a. State MD  10e. Street and Num 220 Som 11. Marital Status 1 Never Marrie 3X Widowed	754   Sex 15   M 2□F 7.Ag	74 Yrs.  10c. City, Town or	Months Days  Location	If Under 24 Hrs	8. Date of Birt (Month, Da Jun 9,		9. Birthplace (State or Forei	
217-20-0 Usual Residence of 10a. State MD  10e. Street and Num 220 Som 11. Marital Status 1 Never Marrie 3X Widowed	754 Decedent 10b. County Allegany ber erville Ave.	M 2□F   -	74 Yrs.	Months Days  Location		Jun 9,	1932	Birthplace (State or Forei Country)
10a. State MD  10e. Street and Num  220 Som  11. Marital Status  1 \( \text{Never Marrie} \)	Allegany ber erville Ave.	. Apt 407						Country
3X Widowed	erville Ave.		1					10d. Inside City Limi
3X Widowed	od 2 Married			10f. Zip Code	0.4.5.00		-	f What Country?
3X Widowed	ed 2 Married		5		21502	Specific Ves or No		ISA ace - American Indian,
(Speci	+ Divolced	<ol> <li>Was Decedent Armed Forces:</li> <li>1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:</li> </ol>	No	3. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 No	Specify:	to Rican, etc.)		lack, White, etc.
Elementary/Secon		ation completed) College (1-4or	5+) (Gi	ive kind of work done in DO NOT use retired	during most of wa		16b. Kind of I	Business/Industry
	Eirst, Middle, Last)		carm	an	18. Mother's Na			
Labor A		/laffley			Helen	Jones C	lawson	
19a. Informant's Na				ailing Address (Street 3 Flintstone	and Number or R	urai Route Numbe Rd Clear	er, City or Town Ville	PA 15535
1 XBurial 2	☐Cremation 3 ☐Re	emoval from State	cemetery, o	crematory or other plac	CB)	7/18/2006		erland MD
1 1/1/1/	MM 7	hlu	U	108 Viro	inia Avenu	ie: Cumbei	rland. MD	. 21502
Sequentially list cor if any, leading to im cause. Enter Unde Cause (Disease or that initiated events resulting in death) L	nditions, mediate riving injury	Pul Due to (cras	monares dis	,	nosis			
	months?	1 Live birth	2 Fetal death	3 □Ectopic pregnanc 5 □ Other (specify) □	у			Date of delivery Month Day Year
C L	ronic t	Ti Ine	y Dise	ase				ontribute to the cause of death
Chr	onic O	bstruc	tine P	ulmonar	y Disea	auto	psy ormed?	b. Were autopsy findings avail prior to completion of cause death? 1 ☐ Yes 2 ☐ No
25. Was case refer examiner?	. н	ospital:		_ Ott	oor	, ,		
	INO	28a. Date of In	jury 28b. Tim	ne of 28c. Inju	ry at rk?	· · · · · · · · · · · · · · · · · · ·		
3 Suicide 4 Homicide	6 Could not be determined	28e. Place of li building,	njury - At home, farm etc. (Specify)	, street, factory, office				mber or Rural Route Number,
29a. Certifier (Check only one) 29b. Signature and	1 Certifying Phys 2 Medical Examin	ner: On the basis	of examination and/o	leath occurred at the to or investigation, in my (	me, date and place opinion, death oc	ce, and due to the curred at the time,	cause(s) and i date and place	manner as stated. e, and due to the cause(s)
≥ 29b. Signature and	title of certifier	1. Chol	auí	29c. Licen:	8853		29d. Date sign	ned (Month, Day, Year)
Medical Certification: To be Completed by Frigated the Completed by Frigated the Completed by Frigated the Completed by Frigated the Completed by Frigated by Frig	John A  19a. Informant's Na Barbara  20a. Method of Disp  1	19a. Informant's Name/Relationship (Type Barbara Beck  20a. Method of Disposition  1	John Alexander Maffley  19a. Informant's Name/Relationship (Type, Print)  Barbara Beck  20a. Method of Disposition  1	John Alexander Maffley  19a. Informant's Name/Relationship (Type, Print)  Barbara Beck  20a. Method of Disposition  1	John Alexander Maffley  19a. Informant's Name/Relationship (Type, Print)  Barbara Beck  20a. Method of Disposition    IXBurial 2   Cremation 3   Removal from State 4   Donation 5   Other (Specify)  21. Signature of Funeral Service Licenses 2. Sunset Memorial Park 2. Name and Address Starpel 1. Signature of Funeral Service Licenses 2. Name and Address Starpel 2. Name and Address Starpel 1. Signature of Funeral Service Licenses 2. Name and Address Starpel 1. Signature of Funeral Service Licenses 2. Name and Address Starpel 1. Signature of Funeral Service Licenses 2. Name and Address Starpel 1. Signature of Funeral Service Licenses 2. Name and Address Starpel 1. Signature of Funeral Service Licenses 2. Name and Address Starpel 1. Signature of Funeral Service Licenses 2. Name and Address Starpel 1. Signature of Funeral Service Licenses 2. Name and Address Starpel 1. Signature of Funeral Service Licenses 2. Name and Address Starpel 1. Signature of Funeral Service Licenses 2. Name and Address Starpel 1. Signature of Funeral Service Licenses 2. Name and Address Starpel 1. Signature of Funeral Service Licenses 2. Name and Address Starpel 1. Signature of Funeral Service Licenses 2. Name and Address Starpel 1. Signature of Funeral Service Licenses 2. Name and Address Starpel 1. Signature of Funeral Service Licenses 2. Name and Address Starpel 1. Signature of Funeral Service Licenses 2. Name and Address Starpel 1. Signature of Starpel 1. Signature of Starpel 1. Signature of Starpel 1. Signature of Starpel 1. Signature 1. Sig	John Alexander Maffley   Helen	John Alexander Maffley   Helen Jones C	John Alexander Maffley

DHMH 17 Rev 1/2001

ORIGINAL

06-04862 Mario Roel Perez

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar				Cer	tificate (	of De	ath			F	Reg. No.	4	JUI	) (	010
Physicia		1. Decedent's Nam	e (First, Midd	lle,Last)					_			2. Date of De Month	ath Day	Year		3 Time of D	
dical Exami	ner	Mar	io		Roe	1	Per	ez				July 9, 20	006			0443 h	rs
		4a. Facility Name ( 2400 Tucke		on, give str	eet and nu	imber)			y, Town, or rt Washir		of Death			County of		3	
Funeral		5. Social Security N	Number	6. Sex		7. Age (In yrs 1	ast birthday)	If U	Inder 1 Yea	r If Unde	r 24Hrs	8. Date of B	irth(MM/D	D/YYYY)	9. Birth	place (State	e or
Director		none		1 <b>X</b> M	2 F	28	Y	rs Mo	nths Day	s Hours	Min	Sept.	4,19	977	Foreign Gou	atem	ala
<u> </u>	- }	Usual Residence o 10a State	f Decedent 10b. County			10e City	Town or Loc	ation				_			1	10d Inside	City Limits
nd show any ree.	_	MD		nce (	Geor		Fort		hingt	con							2 <b>X</b> No
eath with the Maryland items 23a or 28a-f show ust he notified at once.	Director	10e Street and Nu		Mill	l Ro	ad #02			Zip Code 20744	1			10g Citize	en of Wha		,	
D 21215-0036 should be filed within 72 hours after death with the Maryland and Mental Hygiene 7 is marked other than "natural", or items 23a or 28a-f she atte event, the Medical Examiner must he notified at once	Funeral	11. Marital Status  1 X Never Marri  3 Widowed		12 larried 1 vorced If Ye	Armed F Yes	2 X No	lf	Yes, sp	edent of His ecify Cubar	n, Mexican, Gua	Puerto I	ecify Yes or N Rican, etc.) alan		White,		an Indian, B te	Black,
ours aft tural" amine	d by	15. Decedent's E		110	Dates:		16a. Deced	ent's Usi	ual Occupat	tion (Give I				nd of Bus	iness/In	dustry	
21215-0036  Juld be filed within 72 hours after do Mental Hygione marked other than "natural", or event, the Medical Examiner m	Completed	Elementary/Sec	ondary (0-12)		College (	1-4 or 5+)	_		working life entei		use retin	ed)	Co	onst	ruc	tion	
5-0036 led within Hygiene other than	Š	17 Father's Name								18.Mother	's Name	(First, Middle,	Maiden S	urname)			
2121 uld be fil Mental I- marked c event, j	Be	Telmo 1					1					ia Pei					
e, MD 21  I and 2 should Health and Me item 27 is ma	To	19a Informant's Na Telmo I					100	8 P	owdei	r Mi		Road #	#02 I	Fort	: Wa		gton,
- s - e		20a Method of Dis 1 XBurial 2	Crematio		Removal fi	rom State	Place of Disp crematory or ezalt	other pla	ice)	1	7/14	Date 4 / 0 6	Oue	ezal ezal	ter	eque	,
Baltimo permit Page Department o Important: injury or oth		4 Donation 5 21. Signature of Eu	Other Superior		1 7	2						I FUNI					Α.
P		Miles	1 Ky	ulex			9	241	Col	umbia	a B	lvd.S:	ilve	r Sp	orin	g,Md	20910
Physician /Medical		23a Part I Enjerti failure, kist or Immediate Cause	nly one cause	on each li		caused the death	. Do not ente	r the mo	ae ot ayıng,	such as c	ardiac or	respiratory a	rrest, snoc	k, or nea	rt	Between	ate Interval Onset and eath
⁼xaminer		or condition resulti				a consequence o	of):										
	niner	Sequentially list co if any, leading to in cause. Enter Under	nmediate erlyi <mark>ng</mark> Cause		to (or as	a consequence o	f):										
ted 1 unsit	Examiner	(Disease or injury events resulting in		Due d.	to (or as	a consequence o	of):										
760, icate be executed physician and the burial - transit	n/Medical	UNPENDED	)	$\neg$	MENDED								,				
3760, ficate be g physici s the buri	_/Me	IF FEMALE: 23b. Was decedent				outcome of preg		Fetal dea	ath 3	Ectopic	c pregna	ncv		Date of o	delivery Da	ıv	Year
Division of Vital Records, P.O. Box 68760, within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Physicia	past 12 month		nknown g		nant at time of de	oth -	Other (S				,				,	
P.O. Es that the gned by the detached	ģ	Part II. Other sign	ificant cond	itions cor	ntributing t	o death but not r	esulting in the	e underly	ying cause s	given in Pa	art I					e cause of	
rds, require been si hould b	Completed			-								24a Wa				psy finding	s available
tal Records cian: The law requi certificate has been ector, page 2 should	dwc					• ·							ormed?	de	eath?		No
R. The Tiffical or. pa		25. Was case refe	rred to medic	al					26.Place	e of Death	(Check o			3			
Vita hysicia this cer Il direct	o Be	examiner?	2 No	Hosp	oital: 1	Inpatient 2	ER/Outpatie	ent 3	DOA	Other <sub>4</sub>	Nursing	g Home 5	Residen	ce 6 🗸	Other:	Scene	
nding Phyth. th. r: After tleefuneral	-	27. Manner of Dea	ath 5 Per	nding	28a, Date Jul 9, 2	e of Injury h. Day,Year) 1006	28b. Time o 0356 hrs	of Injury		ry at Work		28d Describe Driver auto	how injur	y occurre bject c	d ollision		
Divisior spital or Attenchours after death meral Director:	ertification	2 🗸 Accident 3 Suicide	6 Co	estigation ald not be		ce of Injury - At h		reet, fac	tory, office l	building, et		28f. Location or Town,	State)				
Hospital 24 hours Funeral	0	4 Homicide 29a Certifier		ermined Physician:	1	Local Stre		curred at	the time, d	ate and pla		due to the car					)
To the I within 2 To the I complete	Medical		Medical Ex	aminer:Or an		of examination a			n my opinior	n, death oc			e and plac	e, and du	ie to the	cause(s)	
v	Σ	29b Signature and	a title of certif	ier		12	J		O.C.	se number .M.E.				ate signe 9, 2006		h, Day, Yea	r)
		30. Name and add															
		Zabiullah A				cal Examine			reet, Bal	timore, I	MD 212	201					
S Regis	tate		JUL <sup>ay, Y</sup> Ta	0 200	16 32	egistrar's Signat	5. A	reste									

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day John M Pasola 10:50 a M 3, 2006 July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 4702 Coachway Drive
5. Social Security Number 6. Montgomery

9. Birthplace (State or Foreign Country) Rockville If Under 1 Year If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months Hours 1X M 2 ☐ F Yrs Director 164-22-6609 76 January 1, 1930 Pennsylvania Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location r then "naturel", or Items 23a or 28a-f ehow the Medical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2 😿 No Directo Maryland Montgomery Rockville 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4702 Coachway Drive 20852 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. within 72 hours after 1 Never Married 2 T Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify.White δ 3 ☐ Widowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry e filed within at Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) 12 Police Officer Law Enforcement injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Pages 1 and 2 should be fill ment of Health and Mental H tant: If Item 27 Is marked other Be Adam Pcola Susan Alusik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4702 Coachway Drive, Bockville, Maryland 2085
Date 20c. Location - City or Town, State Mary Pasola/ Wife Maryland 20852 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State July 2006 permit. Page Department of Important: If eny injuryor once. 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Silver Spring, Maryland 21. Signature of Funeral Service Licens Francis d. Collins Funeral Home Inc. 500 University Blvd, W., Silver Spring, MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List on a one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Coronary Heart Disease Years /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a considered of Examiner signed by the ettending physicien end a be detached for use as the burial-transit certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery The law requires that the death 3 ☐Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) o 9☐ Unknown 9 □ Unknown ۵ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Records. been si should 1 ☐ Yes 2 X No 3 ☐ Probably 4 ☐ Unknown Completed Congestive Heart Failure 24b. Were autopsy findings available prior to completion of cause of death? page 2 s 24a. Was an hes autopsy performed? After this certificate funeral director, pag 2□ No 1 Yes 2€ No 1 ☐ Yes of Vital Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient ဥ 1 ☐ Yes 2 ₩ No 3□ DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred Attending F 5 Pending investigation Division 1 Natural Injury death. To the Hospital or Attendi within 24 hours after death. To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Sertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D06019 July 6, 2006 anner M.P. EW.S 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Harris Kenner, M.D. 5454 Wisconsin Avenue, #925, Chevy Chase, MD 20815 32 Registrar's Signature 31. Date filed (Month, Day, Year) State MALLEY 2006 Registrar

			1 - For State Registrar	State o	of Maryla			ent of H a <i>te of L</i>		nd M	ental Hyg R	iene og. No.	20	06	23159
	Disc. of the		1. Decedent's Name (First, Middle,	Last)							2. Date of Dea	th	,		3. Time of Death
	Physici /Medi		Robert David Pe	av1er							June 30	, 20		ear ear	10:30 A <sup>M</sup>
	Examir		4a. Facility Name (If not institution,		ımber)		4b. C	ity, Town, or	Location of	Death		4c. C	ounty of	Death	
			16310 Oxford Co	urt				Bowi					Prin	ce G	Georges
	Funeral			3.Sex 1 2 M 2 ☐ F	7. Age (In yrs	s. last birthday)	If Un Mont	der 1 Year	If Under 2	4 Hrs. Min.	8. Date of Birth (Month, Day,	Year)		Birthpl Count	ace (State or Foreign try)
	Director		415-46-6232 Usual Residence of Decedent		74	Yrs.					Sept. 2	, 19		TN_	
	land bw		10a. State 10b. County		10c. C	City, Town or Lo	ocation							10	Od. Inside City Limits
	Mary Heth	ठ्	MD Prince	Georges		Bowie								1	1 ☐ Yes 2 ☐XNo
	28a	Jec.	10e. Street and Number				10f.	Zip Code			1	0g. Citize	on of Wh	at Count	trv?
	h with	D E	16310 Oxford Co	urt				20715					USA		
	deat	Funeral Director	11. Marital Status	12. Was Dec	edent Ever in	U.S. 13.	Was De		spanic Origi	in? (Spe	cify Yes or No- Rican, etc.)		Race -		an Indian,
21215-0036	permit. Peges 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or Items 23e or 28e-f show any fujury or other traumatic event, the Medical Examinar must be notified at once.		1 ☐ Never Married 2 📉 Marrie 3 ☐ Widowed 4 ☐ Divorced	Armed Fo d 1 [X]Yes If Yes, Gi Year or D	2 No			2 No	Specify:	Puerto F	tican, etc.)	S	Black, Specify:	White, 6	
ŏ	2 hou	Completed by	15. Decedent's	Education		16a. Dece	dent's U	sual Occupa	tion			16b. Kind	of Busi		
218	Bo "a	ple	(Specify only highest Elementary/Secondary (0-12)	grade completed) College (	1-4or 5+)	(Give	kind of DO NO	work done d Tuse retired)	uring most o	of workin	)g				
2	or th	Con	, , , , , , , , , , , , , , , , , , , ,	4		Aer	o-Sp	ace So	cienti	İst		NA	ASA		
b	d oth	Be (	17. Father's Name (First, Middle, La	ist)					18. Mother	s Name	(First, Middle, M	Maiden S	u <i>mame)</i>		
Maryland	Men Men arke	٦ ک	William David								Byrd				
<u>la</u>	2 sh and 1s m		19a. Informant's Name/Relationship								Route Number,		Town, St	ate, Zip	Code)
a)	l and Health In 27	1	Carmie W. Peav	ler/ Wife					Cour		Bowie, N		2071		
altimore,	If It of the or of or of		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3	Removal from	State _	Place of Dispo	natory o	or other place							wn, State
Ë	t. Pertant		4 Donation 5 Other (Spe		La	kemont Gardens	-			7/7/2					le, MD
Bal	Depermine permine	21. Signature of Funeral Service				TOU	UU Anr	iapoli	s Kc		7ie,	Fur MD	nera 207	1 Home 15	
П			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that only one cause on e	caused the dea	ith. Do not ent	er the m	ode of dying	, such as ca	ardiac or	respiratory arre	st,			Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Diffu	se La	rge B	cel	Lym	phomi	a					Onset and Death
	/Medical Examiner		resulting in death)	Due to	(or as a conse	quence of):		/	-						J MUNANS
	*	_	Sequentially list conditions	b											
	led isit	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	(or as a conse	quence of):								1	
	xecul and al-trar	хап	that initiated events resulting in death) Last	c. Due to	(or as a conse	quence of):						_		-	
8760	cate be executed physicien and the burial-transit	dical													
89	flicate g phy: as the	edic		d					-						
Вох	eath certific attending p	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out								23	d. Date o	f deliver	v
Ď.	death e atte	Icla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregr	ointh 2 ☐ Fet lant at time of			pregnancy (specify)					Month		Day Year
о. О	t the by th tache	hys	9 🗆 Unknown	9□ Unkn	own										
S,	law requires that the death certifi as been signed by the attending ( 2 should be detached for use as	ру Р	Part II. Other significant conditions	s contributing to de	eath but not re	sulting in the u	nderlyin	g cause givei	n in Part I.		23e. Did tob	acco use	contribu	ite to the	cause of death?
Records,	w require been si should t										1 ☐ Ye	s 2/2	No 31	] Proba	bly 4 ∐Unknown
ပ္ပ	lawr as be 2 sh	Completed									24a. Was an		24b. We	e autop:	sy findings available pletion of cause of
_	The ete ha	200						_			autopsy perform	ed?	dea	th?	Pietion of cause of □ No
Vital	ysician: The is certificete hi director, page	Be (	25. Was case referred to medical examiner?					2 4	26. Place of	f Death	Check only one				
<u></u>	Physis this c	2	1 ☐ Yes 2 No			] ER/Outpatien	t 3 🗆		4 LI Nursi	ing Hom	e 5/ Resider	nce 6	Other (	Specify)	
Ĕ	ding P	ü	27. Manner of Death  1 Natural 5 ☐ Pending	28a. Date (Moni	of Injury th, Day Year)	28b. Time of Injury		28c. Injury : Work?	at	28	Bd. Describe how	w injury o	ccurred		
Sic	death.	cat	2 Accident investigat 3 Suicide 6 Could not	ha			М		es 2∐No						
Division of	ours after ours after neral Direc filled in by	Certification:	4 ☐ Homicide determine	ed 286. Place buildi	of Injury - At r ng, etc. <i>(Speci</i>	nome, farm, str fy)	eet, fact	ory, office		28	Bf. Location (Str. City or Town,	eet and f State)	Vumber (	or Rural	Route Number,
	To the Hospital or Attending Physician: within 24 hours alter death. To the Funeral Director: After this certific completely filled in by the funeral director,	edical (	29a. Certifier 1 Certifying (Check only one)	Physician: To the aminer: On the ba	best of my kn asis of examinater stated.	owledge, death ation and/or inv	occurre estigati	ed at the time on, in my opi	, date and p nion, death	place, ar occurred	nd due to the ca d at the time, da	use(s) ar te and pl	nd manne ace, and	er as star due to t	ted. he cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier	/	-		2	9c. License	number		29	d. Date s	igned (A	fonth, D	ay, Year)
			1 Tre V	~	M.	D.		D629	773			7/	5/00	5	
			30. Name and address of person wh				Print)	- 0-				110	100		
				North Br				re,	MD.	212	31				
	Sta		31. Date filed (Month, Day, Year)	2006 32/R	egistrar's Sign	ature A	· m								
	Registr	11	JUL U	2000	and a	30 /2020	WA	2							

06-05152 Isaiah Price

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 2006 23160 1. For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ 3 Time of Death Month Day July 17, 2006 Medical Examiner Webster Price 1208 hrs Isaiah Russell David 4a. Facility Name (if not institution, give street and number 4b. City. Town, or Location of Death c. County of Death Memorial Hospital Cumberland Allegany 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or Funeral Country Maryland Months Days Hours Min Director 214-75-0430 1 X M 2 F 19 02/28/2006 Usual Residence of Decedent 'n 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits 28a-f show Yes 2 X No items 23a or 28a-f shoust be notified at once. MD Little Orleans after death with the Maryland Allegany Director 10e. Street and Numbe 10f. Zip Code 10g, Citizen of What Country 11417 Price Road, NE 21766 USA Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. 14. Race - American Indian, Black, Armed Forces? White etc. 1 XNever Married 2 Married Yes f Yes, Give Year 3 Widowed 1 Yes 2 X No specify: 4 Divorced Specify White ges I and 2 should be filed within 72 hours after to f Health and Mental Hygiene.

I fitem 27 is marked other than "natural", ther traumatic event, the Medical Examiner. ş or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Baltimore, MD 21215-0036 0 Infant 17 Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Be Russell Price Rebekah Ann Monn 19a Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rebekah Ann Monn / mother 11417 Price Road, NE, Little Orleans, MD 21766 20a Method of Disposition 20b Place of Disposition (Name of cemetery Date 20c. Location - City or Town, State crematory or other place)
Price Memorial or other 1 X Burial 2 Cremation 3 Removal from State Pages 1 Department of Donation 5 Other Specify Weslevan Cemetery 07/21/2006 Little Orleans. 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Adams Family Funeral Home, P.A. Illa. Part I Enter the disease, or complications that caused the death Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval Between Onset and failure. List only one cause on each line Machinal Death Sudden unexplained death in infancy Examine or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate Examiner Due to (or as a consequence of) (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last and an/Medical X UNPENDED AMENDED physician item#23a,27,28a-f, perME,g860, 10/2/06 TT Box 68760. 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy Month Day 2 past 12 months? Pregnant at time of death **Physici**; 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown the signed by t Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e Did tobacco use contribute to the cause of death? 3 1 Yes 2 No 3 Probably 4 V Unknown Completed After this certificate has been simeral director, bage 2 should 24a Was an 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? ✓ Yes 2 ✓ Yes No To the Hospital or Attending Physician: 25. Was case referred to medical 26 Place of Death (Check only one) Other<sub>4</sub> examiner? Inpatient 2 V ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Other 1 V Yes 2 ٩ 28a. Date of Injury (Month, Day, Year 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification: Natural 5 Pending Yes 2 X No Fnd 7/17/2006 Fnd 11:00 am unk 2 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City Little Orleans, MPrice Road 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Suicide 6 X Could not be within 24 hours a To the Funeral I determined (Specify) found at home 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Wedical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated Signature and title of certifie 29c License number 29d. Date signed (Month, Day Year) O.C.M.E July 18, 2006

State Registra

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OCMF 2006

C

Patricia Aronica-Pollak MD.

31. Date filed (Month, Day, Year) 4 2006

30. Name and address of person who completed cause of death (Item 23a)

111 Penn Street, Baltimore, MD 21201

Assistant Medical Examiner

32. Registrar's Signature

			1 - For State Registrar	State	of Maryla		artment of I				giene Reg. No.	106	23	161
	Dhysisi	an	1. Decedent's Name (First, Middle	e, Last)						2. Date of Dea _Month	ath Day	Year	3. Time of	
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	Examin		4a. Facility Name (If not institution	- 5	ımber)		4b. City, Town, o		of Death			y of Death		
			222 Sycamore				E1kton		0411		Cec			
	Funeral Director		5. Social Security Number 197–30–5261	6. Sex 1 (X) M 2 □ F	7. Age (In yrs	. last birthday) Yrs.	If Under 1 Year Months Days	If Under Hours	Min.	3. Date of Birt (Month, Day JAN 16,	y, Year)	Cou	place (State ontry) NSY1vai	_
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/and	Jid be f Aental P rked of tic eve	To Be	Michael Richar		s					Miller				
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Interpretat: If them 27 is marked other than "natural; or items 23a or 28a-f show mit pring or other traumatic event, I a Medical Examinat must be notified at once.		19a. Informant's Name/Relations Virginia M. Ph		fe		ng Address (Street Sycamore							
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Baltimore,	permit. Pages 1 and: Department of Health Important: If item 27 any injury or other tr		21. Signature of Fundamental W	ensee				of Facility Lec	e Funera			ert, P.A. MD 20736
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10	ding Phy h. After this funeral d	n: To	27. Manner of Death	28a. Date of Injur (Month, Day	y 28b. Ti		28c. Injury at Work?		28d. Describe h			(9)
sior	Attending r death. ector: After by the fune	catlo	1 Accident 5 Pending 2 Accident investiga	lion		М	1 🗆 Yes	s 2□No				
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	5		30. Name and address of person wi									
	<b>V</b>		Michael Lapenta 31. Date filed (Month, Day, Year)	M.D. 445	Defense	Highw	ay, Anı	napolis	, Maryla	nd 214	U1	
	St Regist	ate rar	31. Date filed (Mornir, Day, 19a)	0 7 2006	s Signature	s do	wie					

			For State Registrar	State of Ma	ryland / De		nt of H	lealth a		ental Hyg		006	23163
,	2%	0.00	1. Decedent's Name (First, Middle, Last)							2. Date of Dea Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Samuel Michael R	Rosenblatt						July	6,	2006	5:40A. M
	Examin	100	4a. Facility Name (If not institution, give s			1		Chago	f Death			County of Dea	
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	Funeral Director		100 11 1000	(M 2□F	76 Y	Month		Hours	Min.	8. Date of Birtl Month Day June27,	1930	New	York, N.Y.
	and **		Usual Residence of Decedent  10a, State 10b, County		10c. City, Town	or Location							10d. Inside City Limits
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	be filed within 72 hours atter death with the Maryland Hygiene. Hygiene. 4 Hygiene. d other then "natural", or items 23a or 28a-f show event, the Medical Examina must be notified at	Funeral Director	3406 Woolsey Drive	2		10f. 2	Zip Code	20815			109. Citiz Uni	ted St	ountry? ates
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/Jar	Mental Mental Mental Mrked c	To B	Abraham			nblatt		Hanna				Cohen	
Man	od 2 sho lith and 27 is m		19a. Informant's Name/Relationship (Ty Irma F. Rosenblatt		19b. 1	Mailing Addre	1sey	and Numbe Drive	chev	Route Numbe 7y Chas	e, City or	Town, State, arylane	Zip Code) d 20815
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8	/Medical Examiner		disease or condition resulting in death)		consequence of	·):							* /
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.О. Вох	0 0 2	Physician/Med	In the past 12 months?  1 ☐ Yes 2 ☐ No 9 ☐ Unknown	1□Live birth 4□Pregnant at 9□Unknown		3 □Ectopic 5 □ Other		у				Month	Day Year
Д.	res that the de signed by the a be detached f		Part II. Other significant conditions con	ntributing to death bu	it not resulting in	the underlyin	g cause giv	ven in Part I.		23e. Did to	obacco u	**	to the cause of death?
ord	w require been signated should b	ted	Chronic reno	11 +9/1	ure					101	Yes 2	ZNo 3□F	Probably 4 □Unknown
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ta	Physician: The la rthis certificate has ral director, page 2	0	25. Was case referred to medical					26. Place	of Death	(Check only o	2 No 2000 No	1210	3 202110
<u>&gt;</u>	ysici nis cer direc	To B	examiner? 1 ☐ Yes 2 ☒ No	Hospital: 1 🗌 Inpatie	nt 2 ER/Out	patient 3	DOA Ott	her: 4 □ Nu	irsing Hom	ne 5 Resid	dence (	6 □Other (Sp	ecify)
o uo	Attanding Physician: r death. ector: After this certifice by the funeral director. I		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day		me of jury M	28c. Inju Wo 1 [	ryat ork? ]Yes 2 ⊡l		8d. Describe	how injur	y occurred	
Division of Vital Records,	To the Hospital or Attanding Ph Within 24 hours atter death. To the Funeral Director: Atter th completely filled in by the funeral	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc		m, street, fac	tory, office		2	28f. Location (S City or Tou			Rural Route Number,
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	Mithin 2 To the I	Medical	29b. Signature and title of certifier	and manner sta	lu l	24 - 1-		se number	10			1	nth, Day, Year)
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			30 Name and address of person who c	Valy ///	eath (Item, 23a) (	Kvi//	e Pil	te, G	-100	, Roci	KVI	le, m	V 20852
	St Regist	ate trar	31. Date filed (Month, Day, Year)	92. Augistra	ar s Signature	Speed							

DHMH 17 Rev 1/2001

			1 - For State Registrar	State of Mary		tificate of			a. No.	2.3164
	Physici	an	Decedent's Name (First, Middle, Last)	DIOF				Date of Death Month	Day Year	3. Time of Death
	/Media	al	MARY F.  4a. Facility Name (If not institution, give si	RICE		4h City Town o	r Location of Death	ILY 7, 2	4c. County of De	1:00P M
	Examir	er	1708 Hickory Kno				Spring		Montgo	
	Funeral Director		102-22-8174	M 2 K 7. Age (In )	rs. last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. 8 Hours Min.	Date of Birth (Month, Day, )	(ear) 9. Bi 1922 We	nthplace (State or Foreign Jountry) st Virginia
	/land		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				10d. Inside City Limits
	e Man ta-feh	ctor	Md. Montgome	ery	Sandy S	pring				1 ☐ Yes 2 🔀 No
	23a or 28	Funeral Director	10e. Street and Number 1708 Hickory Kno.	ll Road		10f. Zip Code	20860	100	g. Citizen of What C United S	
Maryland 21215-0036	4 within 72 hours after death with the Maryland liene. r than "natural", or Iteme 23a or 28a-f ehow the Macikal Examinar must be notified at	ğ	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ② No If Yes, Give Year or Dates:		I□Yes 2⊠∕No			14. Race - Arr Black, Wh Specify:	
15-(	"natu	lete	15. Decedent's Educ (Specify only highest grade	ation completed)	16a. Deced	lent's Usual Occup kind of work done	nation during most of working d)	16	6b. Kind of Busines	s/Industry
12	filed withir Hygiene other than	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)		memaker	1)		Own Hor	me
b	e filed al Hygid other vent.	BeC	17. Father's Name (First, Middle, Last)				18. Mother's Name (F	First, Middle, Ma	aiden Sumame)	
ylaı	ould b Ments arked	To.	Worth B. Form				Lilian,	Treib		
, Mar	and 2 sh ealth and n 27 ls m		James K. Rice / 1	Husband	1708	Hickory	and Number or Rural F Knoll Road	l,Sandy	Spring, 1	Md. 20860
Baltimore,	permit. Pages 1 and 2 should be filed w Depertment of Health and Mental Hygies Important: If tem 27 is marked other it eny injury or other traumatic event. Im once.		20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	RIIOVALI II OIII SLATE		sition (Name of natory or other plac itan Crei			Alexandr:	
Balt	permit. Depert import eny inj		21. Signature of Funeral Service License	y Bark			ss of Facility Barber Fu ox 5038, La			20882
	Physician /Medical Examiner		23a. Part1. Erfer the disease, dr complice shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	Due to (or as a cons	ard fall sequence of):		ng, such as cardiac or r	espiratory arres	it,	Approximate Interval Between Onset and Death
90,	tificate be executed ig physician and as the burial-transit	ıl Examiner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons						
68760,	physics the t	edical	d.							
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of pre 1 Live birth 2 F 4 Pregnant at time of 9 Unknown	etal death 3	Ectopic pregnancy Other (specify)	,		23d. Date of de Month	elivery Day Year
rds, P.	w requires that been signed to should be det	ρ	Part II. Other significant conditions conf	ributing to death but not	resulting in the ur	nderlying cause giv	en in Part I.			to the cause of death? Probably 4 Inknown
I Records,		Completed						24a. Was an autopsy performe	ed? death?	autopsy findings available completion of cause of s 2 \( \subseteq \text{No} \)
Vital	iician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	ospital:		1.045	26. Place of Death (C	Check only one)		
of	Phys r this ral dir	To	1 Yes 2 No	1 Inpatient 2	2 ER/Outpatien 28b. Time of	t 3 DOA Oth	4 Nursing Home	5 Residend		ecify)
on	nding I th. :: After e funer	atlon	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year	r) Injury	Wor	k? Yes 2 □No		inquity occurred	
Division	Hospital or Attending Physician: 4 hours after death. Funeral Director: After this certific tely filled in by the funeral director.	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - A	t home, farm, streecify)	eet, factory, office	28f	Location (Stre City or Town,	et and Number or F State)	iural Route Number,
	To the Hoepital or Attendit within 24 hours after death.  To the Funeral Director: A completely filled in by the fu	Medical C	29a. Certifier 1 Certifying Physic (Check only one) 2 Medical Examin	cian: To the best of my er: On the basis of exam and manner stated.	knowledge, death nination and/or inv	occurred at the tir restigation, in my o	ne, date and place, and pinion, death occurred	due to the cau at the time, date	se(s) and manner a e and place, and du	s stated. e to the cause(s)
	To the within 2 To the complet	ž	29b. Signature and title of certifier			29c. Licens			d. Date signed (Mon	
	10		- Charlostas				793		Tuly 71	
			30. Name and address of person who cor				Philip Sa.	Olno	y, mo	20832
	Sta Registi		31. Date filed (Month, Day, Year)  JUL 1 0 200	)6	B. Ap	while I				

DHMH 17 Rev 1/2001

ADIN VENTURA-RAMOS

Please Type or Print in Black Indelible Ink

UNK UNK	1	- For State	State o		nd / Depa			and	Mental			200	6 2316
Physician		egistrar I. Decedent's Name (First, M	liddle,Last)			tineate of	Death			2. Date of Dea			3. Time of Death
Medical Examine		Adin Ventura								July 1, 20	Day 06	Year	1404 hrs
	4	a Facility Name (if not inst	tution, give s		mber)		b. City, Tow		cation of De	ath	1	ounty of Deat	
		1760 Greenspring					Owings					Itimore Co	
Funeral		5. Social Security Number	6. Sex		7. Age (In yrs la	ast birthday)	If Under 1 Months	Year Days	If Under 24	Ars. 8 Date of B	rth(MM/DE	Forei	rthplace (State or gn
Director	L	Nane		1 2 F	28	Yrs.				Novembe	15,	1977 C	ountryEl Salvador
any		Usual Residence of Decede			10c. City,	Town or Locati	on						10d Inside City Limits
* .	را	Maryland Prin	ce Geor	me!s		Hyatts	ന് 11e						1 Yes 2X No
arylan 8a-f sl at one	$\smile$	10e. Street and Number	ce ceor	.gc s		nyacas	10f. Zip Co	de			l0g. Citizei	n of What Cou	intry?
bith the Maryland \$ 23a or 28a-f show?	5	6905 22nd Place						20	0782		El S	alvador	
with	<u> </u>	11 Marital Status	_		edent Ever in U.					Specify Yes or Nerto Rican, etc.)	)- 14	I. Race - Amer White, etc.	rican Indian, Black,
or items	Funeral	1 Never Married 2	Married	Armed Fo	2 x No								
ral",	2	3 Widowed 4		Yes, Give Year or Dates:			Yes 2			ntral Amer			
2 hours after "natural",	و ا يو	15. Decedent's Education Elementary/Secondary (0		College (1		16a. Decedent during mo	ost of working				160. Kin	d of Business	rindustry
36 hin 72 than cdical	ᇍ	6											n
215-0036 be filed within 7 ntal Hygiene rked other than ent, the Medica	Completed	17. Father's Name (First, Mi	idle, Last)	<del> </del>		l		18	Mother's Na	me (First, Middle,	Maiden Si	ırname)	
215 be fill ntal H riked	e Re	Jose Plutarco V	entura						Ana :	Lidia Ramo	3		
imore, MD 21215-0036  Pages I and 2 should be filted within 72 hours after death with the Maryland ment of Health and Mental Hygine Mental Hygine 1 is marked other than "natural", or items 23a or 28a-fish or other transmite event, the Medical Examiner must be notified at once To De Computed by Ernoral Disorber	^ ا	9 Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, Cit Jose Jovino Ventura Ramos/ Brother 8308 Tahona Drive, Silver Spring, MD 20											e, Zip Code)
MC and 2 salth a rm 27 raum	L	20a Method of Disposition	tura ka	inos/ br		Place of Dispos				Date		cation - City o	r Town, State
<b>9</b> = = = = =			ation 3 3	Removal fro		crematory or oth		31 301110	J	fuly 13,	200. 20	odi.on ony o	, rom, otato
t Pag tment rtant:	J.	4 Donation 5 Othe			Cen	neterio Na				2006			El Salvador
Baltimo permit Page Department of Important:		21. Signature of Funeral Se	144	96						uneral Hom		MD 00	2001
Physician		2 art I Enter the diseas			aused the death					W, Silver			Approximate Interval
/Medical		failure List only one c Immediate Cause (Final dis			ab and Cutti	na Wounds							Between Onset and Death
Examiner		or condition resulting in dea			consequence o								
		Sequentially list conditions,	b_										
	<u>i</u> le	if any, leading to immediate cause. Enter Underlying Ca	use	ue to (or as a	consequence o	ot):							
t.		(Disease or injury that initial events resulting in death). L		ue to (or as a	consequence o	of):							V.
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O, e be ex vsiciar burial	edical	UNPENDED		AMENDED							1004	Data of Jalyan	<u> </u>
of Vital Records, P.O. Box 6876 ing Physician: The law requires that the death certificate After this certificate has been signed by the attending phy ineral director, page 2 should be detached for use as the latest of the state of the sta		IF FEMALE. 23b Was decedent pregnan past 12 months?	in the	1 Live b	outcome of preg pirth		tal death	3	Ectopic pre	gnancy		Date of deliver Ionth	Day Year
th cer trendi	icia	1 Yes 2 No 9	Unknown		ant at time of de	eath 5 Ot	her (Specify	)					
Box he death of the attented hed for use	Phy	Part II. Other significant co		9 Unkno		oculting in the L	nderlying ca	use aivi	en in Part I	23e Did	obacco us	e contribute to	the cause of death?
P.O. s that the gened by e detac	Ş	raitii. Other significant co	multions (	Softi ibutili gite	death but not i	esulting in the c	inderlying ca	idse givi	SITHIT COLL				bably 4 Unknown
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of Vital Records,  ig Physician: The law requin  Wher this certificate has been si	Completed										ormed?	pnor to death?	completion of cause of
Rec The ficate	5							D1	. D	1 🗸 Yes	2 No	1 🗸 Y	es 2 No
ician:	ă۱	25 Was case referred to me examiner?		spital 1	Inpatient 2	ER/Outpatient		In		rsing Home 5	Residenc	e 6 🗸 Othe	ar Scene
n of V fing Phys After thi	위	1 Yes 2 No 27. Manner of Death		28a Date	of Injury	28b Time of I			at Work?	28d. Describe	how injury	occurred	-
on on of the state	ë		Pending	11.4 00	, Day Year)	FOUND: 1400 hrs	1	Ye	2 <b>V</b> No	Subject sta	bbed ar	nd cut	
Division tal or Attendir rs after death al Director: A	fical	2 Accident 3 Suicide 6	Investigation Could not be	28e Plac	e of Injury - At h		et, factory, of	fice buil	ding, etc.			Number or R	ural Route Number, City
Divisior pital or Attenc ours after death eral Director: filled in by the	Certification	4  Homicide	determined		Beside cre	eek				or Town, 1760 Gree		Valley Rd,	Owings Mills, MD
	_									and due to the cau			
To the Howithin 24 h To the Fu	Medical			On the basis and manner s	of examination a stated.	and/or investigat				ed at the time, date			
["]	Ź	29b. Signature and tyle of c	ertifier					icense			[		onth, Day, Year)
			4	1				D.C.M	.C.		July 2	2, 2006	
		30. Name and dress of Mary G/Ripple M	-		se of death (Iten Medical Exa		1 Penn St	reet I	Baltimore	, MD 21201			
- 01				32	0		refer						
Sta Registr	rar	31 Date filed (Month, Day,	07 50	06	egistrar's Signat	J. MA							

		•	For State Registrar	State of Ma	-	partment of learning of the contract of the co		nd Mental Hy	rgiene () () (	23166
<u>.</u> 4.	Physicia /Medic	- 5	1. Decedent's Name (First, Middle, Last) FLBERT	· R	TAH			2. Date of De Month July	Day Ye 3 200	
**	Examin	er	4a. Facility Name (If not institution, give s  1019 Mar1boro Roa  5. Social Security Number 6. Sex	d	e (In yrs. last birthda	4b. City, Town,  Lothia  V) If Under 1 Year	In If Under 2	4 Hrs. 8 Date of Bi	4c. County of E Anne A	
'y. [	Funeral Director				79 Yrs.	Months Days	Hours	Min. (Month, Da	20,1926 I	Country) 11inois 10d. Inside City Limits
the Maryla	r 28e-f eho	Director	MD Anne Ar	undel	Lothia				10g. Citizen of Wha	1 ☐ Yes ¾XNo
d 21215-0036 filed within 72 hours after death with the Maryland	il', or items 23a or 28e-f ehow Sometrer must be partified at	by Funeral D	1019 Mar1boro Roa  11. Marital Status  1  Never Married 2 Married  3 🛣 Widowed 4 Divorced	2. Was Decedent I Armed Forces? 1 XYes 2 N ff Yes, Give Year or Dates:	10	207 Was Decedent of If Yes, specify Cub	Hispanic Origi pan, Mexican,	in? (Specify Yes or N Puerto Rican, etc.)	USA 14. Race - A Black, V Specify:	American Indian, Vhite, etc. White
Maryland 21215-0036 d 2 should be filed within 72 hours aff	Hygiene. other then "natural", or ent, it a Medical Exam	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0·12)	cation	16a. Dec (Giv life.	edent's Usual Occu re kind of work done DO NOT use retire rnalist	during most	of working	16b. Kind of Busine	
aryland Saryland Saryland	e g a	To Be C	17. Father's Name (First, Middle, Last)  James J. Ryan				Don	s Name (First, Middle	oni	
	f Health ar Item 27 is other trsu		19a. Informant's Name/Relationship (Type Anne Ross (Daught 20a. Method of Disposition	er)	1019	Marlboro	Road,	or Rural Route Numb Lothian, Date		
	Department of Important: If it is eny injury or conce.	Ī	1		Arlingto	n Nat. Ce	em. 0	7/26/2006		, VA
/1	ysician and Medical aminer the private the private the private the private the private that	dicai Examiner	shock, or heart failure. List only on firmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	a consequence of): a consequence of): a consequence of):	C PRU	STA	TE CAR	CINOMA	Interval Between Onset and Death  Mary
O. BOX 6.	by the attending p tached for use as	Physician/Mec	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 Fetaf death 3	Ectopic pregnand Other (specify)	Fy		23d. Date of Month	delivery Day Year
S, P	signe d be d	þ	Part II. Other significant conditions con	tributing to death bi	ut not resulting in the	underlying cause gr	ven in Part I.			te to the cause of death?  Probably 4 Dunknown
I Record	cate has been . page 2 shou≀	Completed		***************************************				24a. Was auto perfi 1 🗆 Yes	psy prior deat	e autopsy findings available to completion of cause of h? Yes 2 \( \subseteq \text{No} \)
Division of Vital or Attending Physician: 1	after death.  Director: After this certificate in by the funeral director. pag	Certification: To Be	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation  3 Suicide 6 Could not be	28a. Date of Inju (Month, Da)	Year) Injury	of 28c. Inju	her: 4 🗆 Nurs	o 28f. Location	idence 6 Other (show injury occurred	Specify) r Rural Route Number,
DÍN Hospital or	4 hours Funeral ely filled	edicai Certi	29a. Certifier 1 Certifying Phys	building, etc sician: To the best of ter: On the basis of	c. (Specify)  of my knowledge, dealexamination and/or	ath occurred at the t	ime, date and	place, and due to the	exause(s) and manne date and place, and	or as stated.  due to the cause(s)
To the F	within 24 To the F complete	Medi	29b. Signature and title of outlifier	A Ten	d. Ph	29c. Licen	se number	97	29d. Date signed (M	donth, Day, Year)
	Sta	te	30. Name and address of person who co  SINGH 75.  31. Date filed (Month, Day, Year)  JUL 0 7 20	209 A 32. Pegistra	eath (Item 23a) (Type II A NOVE ar's Signature	Print) PKW	y G.K	EEN BE	LTMD	2077-

State of Maryland / Department of Health and Mental Hygiene U For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Malvin **Physician** Dean Steinback Ju1y4. 2006 8:20P /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Springbrook Nursing Home Silver Spring Montgomery If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday)
71 Yrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□F Days Hours Min Director 191-26-0347 5,1934 Pennsylvania Usual Residence of Decedent 10c. City, Town or Location 10a State 10h County 10d. Inside City Limits 28a-f ehov rthan "natural", or iteme 23a or 28a-f ehov the Madical Examiner must be notified at 1 TYPes 2 □ No Director DC Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1330 Sheridan St. NW 20011 United States of America Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 □Xes 2 □ No Army If Yes, Give Year or Dates: 1952-54 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. permit. Pages 1 and 2 should be filed within 72 hours after of Department of Health and Mental Hygiene. Important: If them 27 is marked other than "natural", or ten eny injury or other traumatic event, the Medical Examinations. 1 ☐ Never Married 2 ☐ XMarried Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 8 Machinist D.C. Government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be George Riley Steinback Violet Smith 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Patricia Simms Steinback - Wife 1330 Sheridan St. NW, Washington, DC 20011 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial ZICremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ft. Lincoln Crematory 07/12/06 Brentwood, Maryland of Funeral Se vice Licensee 22. Name and Address of Facility Hines Rinaldi Funeral Home, Inc. 21. Signature 11800 New Hampshire Road, Silver Spring, MD 20904 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Septicemia **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Cellulitis of Feet Sequentially list conditions, if any, leaving to innectiate cause. Enter Underlying Cause (Disease or injury Dualto (or as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed anding physicien and use as the burial-translt Peripheral Vascular Disease that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 □ Yes 2 □ No Day Month Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Diabetes Mellitus Type 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 XUnknown 24b. Were autopsy findings available prior to completion of cause of death? certificate has autopsy performed' 2□ No 2 XNo 1 Yes After this certification funeral director, i 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4XX Nursing Home 5 Residence 6 Other (Specify) Hospital: Certification; To 2 ER/Outpatient 1 ☐ Yes 2 X No 1 Inpatient 3□ DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? X Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funerel Direct completely filled in by filled in by 4 Homicide 1 🚰 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 12 D52261 July 6, 2006 30. Name and address of person who completed cause of death (Nem 23a) (Type, P/int) Alan R. Segal, MD 1517 Hugo Circíe Silver Spring, MD 20906 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 10 2006 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** Sally Turner Signorelli 2006 July 7:00 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Holy Cross Hospital Montgomery 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year March 23, 19 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 M 2 F 424-32-8809 75 Georgia Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits 28e-f show traumatic avant, the Medical Examinar must be notified at 1 Yes X No Director Maryland Montgomery Burtonsville the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? WITH 26 Scarlet Sage Court 20866 USA 23a death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 🛣 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status Pages 1 and 2 should be filed within 72 hours after nent of Health and Menta! Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 5 If Yes, Give Year or Dates: SpecifyWhite 1 ☐ Yes 2 X No Specify: ξ 3 K Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Health Insurance Claims Processor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ia marked John Robert Hosch Gladys Elizabeth Turner ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Itam 27 other tr Rebecca E. Barrett/ Daughter 6663 Crenshaw Drive, Orlando, Florida 32835 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition July 8, = 5 1 ☐ Burial 2 🖾 Kremation 3 ☐ Removal from State permit. Page Department of Important: if any injury or once. Metropolitan Crematory 4 □ Donation 5 □ Other (Specify) 2006 Alexandria, Virginia 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Francis J. Collins Funeral Home Inc. MU 500 University Blvd, W, Silver Spring, MD 20901 23a. Part1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final Physician disease or condition resulting in death) Lung Cancer /Medical Due to (or as a consequence of): **Examiner** Pneumonia Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury Due to (or as a consequence of) Examine the Hospital or Attending Physician: The law requires that the death certificate be executed ettending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? Month Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No ed by the detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Š Division of Vital Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown Completed Hypertension, Atrial Fibrillation 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 ☐ Yes 2 ☐ No 2**X** No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 ☐ Yes 2 ☐XNo Certification: To this 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Matural 5 Pending 1 □ Yes 2 □ No within 24 hours after death.

To the Funerel Director: A completely filled in by the form 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 THomicide 1 🖰 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) ္ D60826 July 2006 6, snam 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kshama Garg, M.D. 17800 Hollingsworth Driver, Derwood, MD 20855 31. Date filed (Month, Pay, Year) 32. Registrar's Signature State 2006 Registrar

			For State Registrar	State of Marylar	nd / Depa <i>Cei</i>	artment of H <i>tificate of L</i>	ealth and Death		giene 2 () Reg. No.	06	23169
			1. Decedent's Name (First, Middle, Last)					2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic		Margaret She	dlock				July	7200		9:25 P M
	Examir		4a. Fecility Name (If not institution, give s	treet and number)		4b. City, Town, or	Location of Dear	th	4c. County	of Death	
			8202 17th Avenue			Hyattsvi					eorge's
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs.		If Under 1 Year Months Days	Hours Min.	(Month, Da	y, Year)	Cou	
	Director		175-01-2240 Usual Residence of Decedent	94	Yrs.			April .	13,1912	Penr	sylvania
	and and		10a. State 10b. County	10c. C	ity, Town or Lo	cation					10d. Inside City Limits
	f she	ō	W 1 1 P		77	. • 1 7					1 ☐ Yes 2 ☑ No
	28a	Director	Maryland Prince G  10e. Street and Number	eorge s	пуас	tsville 101. Zip Code			10g. Citizen of \	What Cou	ntry?
	3a or		8202 17th Avenue			207	183		III	SA	
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٥	after or its	Ē	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☑ No		f Yes, specify Cubai		to Hican, etc.)		ck, White,	etc.
3	rel',	ρ	3 ☑ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 21⁄2 No	Specify:		Specify	" Wł	nite
Maryland 21215-0036	d within 72 hours after death with the Marylan Jiene. Ir then "naturel", or Iteme 23a or 28a-f ehow The Medical Examinat marat be notified at	Completed	15. Decedent's Educ (Specify only highest grade	cation completed)	(Give	dent's Usual Occupa kind of work done d	uring most of wo	rking	16b. Kind of B	nf/zsenizu	ndustry
7	within ene. then	ğ	Efementary/Secondary (0-12)	College (1-4or 5+)	life. I	DO NOT us e retired;					
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Baltimore,	Pages nent of int: If it		1 ☐ Burial 2 ② Cremation 3 ☐ Re	emoval from State Me	cemetery, crer tropoli	natory or other place tan	9)	_			
	rtant rtant		4 □Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licen		C	rematory  . Name and Addres	Jul	y 8,2006	Alexand	ria,	Virginia
g	permit. Page Department of Important: If eny injury or once.		21. Signature of 1 direction and 200 Kee Closely	$\sim$ 0	Fr	ancis J.	Collins	Funeral	Home,	[nc.	
	_		23a. Part1, Enjer the disease, or complic	cations that caused the dea		O Univers				ring.	MD 20901 Approximate
ь			shock, or heart failure. List only on Immediate Cause (Final	e cause on each line.		,					Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	. Respirator		ure				_	
	Examiner			CACABOOLU PARENTS	quarica oi).						
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9	ding h. After funer	ţi	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	fnjury	Work	? ∕es 2 ∐No		,.,		
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2	2 th 1 c	Certification:	4 Homicide	building, etc. (Spec	ify)			City or Tov	vn, State)		
	Hospital	Medical C	29a. Certifier (Check only one) Cartifying Phys	ician: To the best of my kn ner: On the basis of examin	owledge, death ation and/or in	n occurred at the tim vestigation, in my op	e, date and place pinion, death occ	e, and due to the urred at the time,	cause(s) and ma	inner as s and due t	stated. o the cause(s)
	the de	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number		29d. Date signe	d (Month	Dey, Year)
	5 1 × 10		11/6	Chris-	877	D4547			July 8,		•
1	6		20 Name and address of account of	moleted course of death (%)	m 23a) /Time				Jury O,	2000	
			30. Name and address of person who of Yeheyis Negussie			•	4. Silve	er Sprine	a. MD 20	910	
	Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Sign			, 3227		J, -1		
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Physician 8:05 A.M. ARNOLD 2006 SALUS /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner WASHINGTON BALTIMORE MEDICAL CENTER GLEN BURNIE ANNE ARUNDEL If Under 1 Year | If Under 24 Hrs. | 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month, Day, Year) JAN 26, 1929 6. Sex 9. Birthplace (State or Foreign **Funeral** Days Hours 1 DXM 2 □ F WASHINGTON, D.C. 77 579-34-2258 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or Items 23a or 28a-f show out, the Madical Examiner must be notified at 1 ☐ Yes 2 € No Directo MARYLAND ANNE ARUNDEL SEVERNA PARK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 138 DREXEL DRIVE 21146 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 X Married 1 ☐ Yes 2 ☑ No Specify: WHITE Specify: ۵ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 4 ENTREPRENEUR VARIED Injury or other traumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be fit iment of Health and Mental H lant; If Item 27 is marked ot Be JEREMIAH SALUS REBECCA OFFENBERG ၉ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TODD SALUS/SON 425 LOVE POINT ROAD, STEVENSVILLE, MARYLAND 21666 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Depertment of Important: If eny Injury or once. NATIONAL CREMATORIUM 07/08/2006 FALLS CHURCH, VIRGINIA 5 ☐ Other (Specify) 21. Signature of Fu DANZANSKY-GOLDBERG MEMORIAL CHAPELS, INC. 1170 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death **Physician** obs mature /Medical Due to (or as a consequence of) Examiner S. uentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit resulting in death) Last Due to (or as a consequence of) physicien Physician/Medical the use as attending for use as 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 □ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4☐Pregnant at time of death 5 Other (specify) been signed by the a should be detached to 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s autopsy performed? Yes 20 No 1 ☐ Yes 2 No 1□ Yes or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 No 1 Tes 2 ER/Outpatient 3 DOA this After this funeral of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation To the Hospital or Attendir within 24 hours after death.
To the Funersi Director: At completely filled in by the fur death. 1 ☐ Yes 2 ☐ No 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 THomicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of certifier Name and address of person who completed cause of death (Item 23a) (Type, Print)

State

DHMH 17 Rev 1/2001

31. Date filed (Month Registrar

**ORIGINAL** 

			1 - For State Registrar	of Maryland / I		tment of H		d Mental Hy	giene	06	231	71
	Physici	an	1. Decedent's Name (First, Middle, Last)			-		2. Date of De Month	eath Day	Year	3. Time of [	Death
	/Media		Elizabeth H. Sherbert					July	9	2006	9:45	Дм
	Examir	er	4a. Facility Name (If not institution, give street and 73 Long Creek Drive	number)	4	b. City, Town, or	Location of D			y of Death en Anr	2010	
	Funeral	-	5. Social Security Number 6. Sex	7. Age (In yrs. last bii	rthday)	If Under 1 Year	If Under 24		_			Foreign
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	pu k		Usual Residence of Decedent  10a. State 10b. County	10c. City, Tow	m or Locat	tion			,			
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	286-	Director	Maryland Queen Anne's  10e. Street and Number	Stev	ensvi	10f. Zip Code			10g. Citizen of	What Coun	try?	
	h with	a D	73 Long Creek Drive			2166	66		United			
	ems :	Funerai	11. Marital Status 12. Was D	ecedent Ever in U.S. Forces?	13. Wa			? (Specify Yes or No uerto Rican, etc.)	o- 14. Ra	ce - Americ	an Indian,	
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21215-0036	within 72 hours after death with the Maryland ene. then "netural", or Items 23e or 28e-f ehow he Madical Examiner must be nutitied at	ed b	15. Decedent's Education	r Dates:	Deceden	it's Usual Occupa	ation		16b. Kind of B			
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Maryland	be file	Be	17. Father's Name (First, Middle, Last)					Name (First, Middle	, Maiden Sumai	me)		
2	hould d Mer marke matic	၉	John Henry Norwood  19a. Informant's Name/Relationship (Type, Print)	100	Mailing			ia Buris r Rural Route Numb	- C't - T		2	
S	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other then "netural", or items 23a or 28e-f ehow entry or other traumatic event, the Markical Examiniar must be nutified at once.		Eileen Shreve / Daughte			ng Creek			sville,			1666
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Baltimore,	Page nent c ant: If ary or		1. ☐ Burial 2 ☐ Cremation 3 ☐ Removal fro 4 ☐ Donation 5 ☐ Other (Specify)	m State	-	Mem. Ga	1	7/13/06	Annapo	lis N	Mary 1 an	ı d
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	e death	Physician/Med	1 Yes 2 No 4 Pre	gnant at time of death		topic pregnancy ther (specify)			Mo	onth I	Day Ye	ar
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<u>≤</u> .	ol or At efter of Direct d in by	Certification:	4 Homicide determined bui	ilding, etc. (Specify)	, 311001,	izotory, onice		City or To	vn, State)	o o nurar	AODIO NUMBE	<i>s</i> r,
	To the Hospitel or Attentwithin 24 hours efter deatl To the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Physician: To	the best of my knowledge	e, death oc	curred at the time	e, date and pla	ace, and due to the	cause(s) and ma	anner as sta	ited.	
	To the H within 24 To the F complete	Medicai	one) and m	anner stated.	WOI IIIVUSI			ccured at the time,				
	5 vit o		29b. Signature and title of certifier	111		29c. License			29d. Date signe			
•			30 time and address of person who completed ca	use of death (from 22-1)	(Type B-	1130	118		01-10	- Zex	26	
			Teachen Un, 3	2003 Kes	de /	Re A	Luce	gody,	Len	204	01	1,1
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	Registr	ar	JUL 1 0 2006	A SOUND SO	10							

		ľ	1 - For State Registrar	Sta	te of N	Marylar	nd / Depa	artmer <i>rtifica</i> i					Reg. No.	4 U L	16	231	72
600	Physici	an	Decedent's Name (First, Midd	le, Last)								<ol><li>Date of D Month</li></ol>	eath Day	,	Year	3. Time of D	)eath
	/Medic	-	Sara		L.			Sowe				July		200		0100	М
	Examin	er	4a. Facility Name (If not institution	-						Location	of Death		4c.	County of			
,		-	Anne Arunde   5. Social Security Number	6. Sex			last birthday)	1	nnap	O L 1 S If Under	24 Hrs.	8. Date of Bi	rth			Arundel	
	Funeral Director		498-09-8572	1 □ M 2		87	Yrs.	Months		Hours	Min.	Nov. 1	ay, Year)		Cour	inois	or orgin
. 6	P _		Usual Residence of Decedent					-					,,				
	show	_	MD Ann	y ne Arund	11		Ammon C								1	0d. Inside City 1 ☐ Yes 2	
	8a-f	Director		— Alumo			Annapo						10- 00				Y-V.
	with t		10e. Street and Number 1933 Baltimon	ca Annar	20116	2 R137d		10t. Zij	214	Λα			TOG. CITI	izen of Wh USA		ntry?	
	72 hours after death with the Maryland 'natural', or Itema 23e or 28e-f show Jigal Exaction must be notified at	Completed by Funeral	11. Marital Status			ent Ever in L		Was Dece			igin? (Spe	ecify Yes or N	0-			an Indian,	
ယ	r ker	ᇤ	1 Never Married 2 Ma	rried 1	ned Force ]Yes 2[	es?						ecify Yes or N Rican, etc.)			White,		
21215-0036	ral', o	l by	3 XWidowed 4 □ Divorce	d Yes	es, Give ar or Date	ıs:		1 🗆 Yes	2143 No	Specity:				Specify:		White	
5-0	72 hours natural',	etec	15. Decede (Specify only high	nt's Education est grade comp	leted)		16a. Dece (Give	dent's Usu kind of wo DO NOT u	al Occupa	ition <i>Juring mos</i>	at of works	ng	16b. Ki	ind of Bus	iness/In	dustry	
121	within ene.	Ig II	Elementary/Secondary (0-12)		lege (1-4d	or 5+)	ļ		ise retired,	)			Fduc	catio			
	filed v Hygie other t		17. Father's Name (First, Middle	5 . Last)	1		Teacl	ner		18. Mothe	er's Name	(First, Middle					
an	d be	To Be	Frederick H.		·k						Voi		,		,		
Maryland	2 should be filed within and Mental Hygiene. Is marked other than aumatic event, It e M.	F	19a. Informant's Name/Relation				19b. Maili	ng Addres	s (Street a			l Route Numb	er, City o	r Town, S	tate, Zip	Code)	
	ges 1 and 2 should be filed within 72 ho t of Health and Mental hygiene. If item 27 Is marked other than "natur or other traumatic event, Its Mi-dical		Nancy Beedle	(Daught	er)		1933	Ba1t	imor	e Ann	napo1	is Blv	d., A	Ann.,	MD	21409	
J.	of He of He litem		20a. Method of Disposition 1 X Burial 2 ☐ Cremation	2 []Ba	I from Cha		Place of Dispo	osition (Na matory or	me of other place	9)	C	ate	20c. Lo	cation - C	ity or To	own, State	
Ë	Pa nen ant:		4 Departion 5 Other (		i ironi Sta	Su	nset H	i11 C	emet	ery 7	<b>'-11-</b>	2006	Edwa	ırdsv	i11e	, IL	
Baltimore,	permit. Pages 1 and. Department of Health Important: If item 27 any injury or other tr once.		21. Signature of Funetal Service	Licensee			2:	2. Name a	nd Addres	s of Facili	ty era1	Home,	P. A.				
-	₫ O E a o		/:/-/-		Della Della			12 R	lidge	Lv Av	renue	, Anna	polis	s, MD	214		
Ю			23 Pa 1. Ent - the Isease, of shick, or reart allure. Lis	r complications it only one caus	e on each	sed the dea h line.	ith. Do not en	ter the mo	de of dying	g, such as	cardiac c	r respiratory a	arrest,			Approximate interval Betwee Onset and De	
igt.	Physician /Medical		Immerate Caure Final disease or condition resulting in death)	a	Cas	-deas	c Ar	rhy	the n	100					- 1		
	Examiner	0		D	ue to (or	as a consec	quence of):										
		e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	ue to (or	as a consec	quence of):										
	be executed sician and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>1</b>													
ó	ate be executed hysician and the burial-transit	Exe	resulting in death) Last		ue to (or	as a consec	quence of):										
8760,	ete % et	dical		d													
9	death certifica attending pt d for use as ti	Med	IF FEMALE:								<del></del>		1.				
Вох	ath co	lan/	23b. Was decedent pregnant in the past 12 months?	10	Live birth	me of pregn	af death 3[	]Ectopic p					1	23d. Date Mont		ory Day Ye	ar
0	The law requires that the death certific ate has been signed by the attending p page 2 should be detached for use as	Physician/Me	1 ☐ Yes 2 ØNo 9 ☐ Unknown		Unknown	t at time of o	death 5L	Other (s	pecify)								
9	that the ed by detac		Part fl. Other significant condit	ions contributir	ig to deat	h but not re	sulting in the u	nderlying	cause give	n in Part I	l.	23e. Did	tobacco u	se contrit	oute to th	ne cause of dea	ath?
Records,	uires sign ld be	d by	Dementia	Facti	ire	to The	LAVE					10	Yes 2	□No 3	Prob	ably 4 Un	iknown
Ö	w requir been si should	lete										24a. Wa:	s an	24b. W	ere auto	psy findings av	vailable
Re	he lav e has age 2	Completed											ormed?	pri de	or to co	npletion of cau	use of
of Vital	hysician: The trains certificate ha	60	25. Was case referred to medic	al						26. Place	e of Death	1 Yes	2,2 No	1	Yes	2 No	
$\geq$	ysici is cer direc	ToB	examiner? 1 ☐ Yes 2 ☑ No	Hospital	1 <b>1/2</b> Inpa	atient 2	ER/Outpatie	nt 3 D	OA Othe	).c		ne 5□Res		6 Other	(Specif	y)	
0	Attending Physician: or death. ector: After this certification is the funeral director.		27. Manner of Death 1 ☑ Natural 5 ☐ Pend	28a.	Date of I	Injury Day Year)	28b. Time o	f	28c. Injury Work		-	28d. Describe					
0	andir. ath. or: Af	atlc	2 Accident inves	tigation				М		res 2□	No						
Division	r Atte	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide deter	not be mined 28e.	Place of building	Injury - At h , etc. (Speci	nome, farm, st	reet, factor	y, office			28f. Location City or To	(Street an wn, State	d Number	or Aura	l Route Numbe	9 <i>r</i> ,
	ospital or Attendi hours after death. uneral Director: A ly filled in by the fu																
	To the Hospital or Attending Ph. within 24 hours after death. To the Funeral Director: After thi completely filled in by the funeral.	edical	29a. Certifier 1 Certify (Check only 2 Medica	ing Physician: Il Exeminer: On	To the be the basis d manner	s of examin	owledge, deat ation and/or in	h occurred vestigation	at the time n, in my op	ie, date an pinion, dea	nd place, a ath occurr	and due to the ed at the time	cause(s) date and	and mani i place, ar	ner as s id due to	ated. the cause(s)	
	o the ithin 2 o the	Med	29b. Signature and title of certifi		3 1112111191	Stated.		29	c. License	number			29d. Dat	e signed	(Month,	Day, Year)	
	F ≯F 8		1011	10		2	d m		06	182	29		7	7/,	1	006	
			30. Name and address of person	n who complete	d cause (	of death (fte	m 23a) (Tvpe	Print)			_/			11			
			REYNALDO	LEE-1	LCA	CEA	D MD	210	28 D	Done	to D	rive (	Chest	₹~	MA	2000	5
	Sta		31. Date filed (Month, Day, Yea	' l	00	istrar's Sign	ature	B.	0			(		1			7
	Registi	rar	.1111	n 7 2006	100	Anti-Anti-	100	Magaali	6.0								

06-05084 Alice Sunderland

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar			(	Certifica	ate of i	Death			_F	Reg No.	UUL	
Physicia		1. Decedent's Name	e (First, Middl	e,Last)						2.	Date of Dea Month	ath Day Yea		Time of Death
edical Exami	ner	Alice	Anne :	Sunderla	nd						July 15, 2	2006	"	1807 hrs
de		4a. Facility Name (i					4b	. City, Town, or	Location of	of Death		4c. County	of Death	
		411 Crain H	lighway Ap	partment 1				Glen Burnie				Anne Ar	undel	
Funeral		5 Social Security N	lumber	6. Sex	7. Age (In y	rs. last birtl	nday)	If Under 1 Year	r If Unde	er 24Hrs.	8. Date of 8	irth (MM/DD/YYYY		lace (State or
Director		217-82-70	185		4	5		Months Days	Hours	Min.	01/2	2/1960	Foreign Count	ny) III
				1 M 2 X		<i></i>	Yrs				01/22	2/ 1960	Oddin	ry) HI
۶.		Usual Residence of 10a. State	Decedent 10b. County		100	City, Town	or Locatio	2					110	Od Inside City Limits
W. 3.11		MD	,	e Arundei		only, Town								
and sho	5	כוניו	АПП	e Arunde.	<u> </u>		Al	rnold					'	Yes 2 X No
faryl	ö	10e. Street and Nur	mber					10f. Zip Code				10g Citizen of Wh	nat Country	?
ith the Maryland 23a or 28a-f show any notified at once.	Director	1169 Gi	reen H	ill Road				210	12				USA	
eath with the items 23a	<u>a</u>	11 Marital Status		12. Was E	ecedent Ever	n U.S	13. Was	Decedent of His		gin? (Spec	ify Yes or N			Indian, 8lack,
r death or item must b	Funeral	1 Never Marrie	ed 2 M	airieu	Forces?		If Yes	s, specify Cuban	, Mexican,	, Puerto Ri	can, etc.)	White		
er de		3 Widowed	4 V Div	orced If Yes, Give		ю	1 \	res 2 X No	specify			Specify.	Wr	nite
72 hours after death with the Maryland n "natural", or items 23a or 28a-f she al Examiner must be notified at one	ģ	15. Decedent's Ed		or Dates.		d) 16a. I		Usual Occupat		kind of wor	k done	16b. Kind of Bu	siness/Indi	ustry
2 hou "nat	tec	Elementary/Seco	ondary (0-12)	College	(1-4 or 5+)	-	during mos	st of working life.	DO NOT	use retired	1)			
36 iin 7; han dica	Completed	-	, , ,		2			Homema	ker				Home	
with with her her	υO	17. Father's Name	(First Middle	Last)						's Name (F	irst, Middle.	Maiden Surname	)	
215-003( be filed within ntal Hygiene rked other tha	Be C	Donald 3			11200								,	
2 a 6 a 2	o B	19a Informant's Na			LIACE	196	Mailing	Address /Stree			Anne	mber, City or Tow	n State 7	n Code)
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Z pd 2 m alth		Michael 20a Method of Dis		Tanu/Ex-				on (Name of cer			Date	20c. Location -	City or To	wn State
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Page nent a		4 Donation 5				Metr	o Cre	ematory		July 2	006	Baltir	nore,	MD
Baltimore, permit Pages I as Department of Her Important: If ite		21. Signature of Fu	ineral Service	Lycensee			22. Na	me and Address	of Facility	, D	7 Co	trowna Da	rde Ev	neral Home
<b>∞</b> 89 € E	1	July	4	Janne			1 49	5 Gov. 1	ritch	ie Hv	v. Se	verna Pa	rk. M	D 21146
Physician		23 art I. Enter the			at caused the d	eath. Do no	ot enter the	mode of dying,	such as c	ardiac or re	espiratory ar	rest, shock, or he	art	Approximate Interval 8etween Onset and
/Medical		Immediate Cause (			ications	of chr	onic a	alcoholis	n					Death
Examiner		or condition resulti			s a conseque.		OILLE C	110011011111						
modified to		Sequentially list co	inditions	b.										
	Jer	if any, leading to in	nmediate		s a consequen	ce of).								
	Ē	cause. Enter Unde (Disease or injury t	that initiated	C									_	
ed sit	Examiner	events resulting in	death) Last	,	s a consequen	ce or).								
8760, tificate be executed ag physician and as the burial - transit		LINDENDED		d AMENDE	D.		-							
760, cate be ex physician he burial	n/Medical	X UNPENDED		X AMENDE	item#2		$\Pi,27$	perME,g85	8,8/10	0/06 T	Τ			
8760, tificate be ing physic as the bur	Ž	IF FEMALE: 23b, Was decedent	pregnant in t	-	es, outcome of re birth				Estable	c pregnanc		23d Date of Month		Year
68 certifi nding se as		past 12 months	s?		e birtri egnant at time (			I death 3	coopic	o pregnanc	У	WOTH	Day	real
Records, P.O. Box 6 The law requires that the death cer care has been signed by the attendi page 2 should be detached for use.	Physicia	1 Yes 2	No 9 🗸 Un	Lunauun   '	known		Otne	er (Specify)						
). E the o	Ph	Part II. Other signi	ificant condi	tions contributin	g to death but i	not resulting	g in the un	derlying cause g	given in Pa	art I.	23e. Did	tobacco use contr	ibute to the	cause of death?
P,O s that t gned by	þ	cocai	ne use								1 Y	es 2 No 3	Probab	ly 4 🗸 Unknown
rds, require been sig	Completed										24a Was	san 124b \	Vere autop	sy findings available
SOFC law re has be	ple										auto	psy p		pletion of cause of
Pec The la	E										1 🗸 Yes		✓ Yes	2 No
tal Recinant: The certificate	Φ	25. Was case refer	red to medica	al						(Check onl	ly one)			
/ita	o B	examiner?	2 No	Hospital 1	Inpatient 2	ER/O	utpatient	3 DOA	Other 4	Nursing I	Home 5	Residence 6	/ Other S	cene
of \ing Phy	⊢	27. Manner of Dea		28a. D	ate of Injury onth, Day, Year)	28b.	Time of Inj	ury 28c. Inju	ry at Work	? 28	3d. Describe	how injury occurr	ed	
on on on on the function of further the fu	ion	1 X Natural	5 Pen		ontn, Day, Year)			1`	Yes 2	No				
iSic Atte r dea ecto by th	icat	2 Accident	r	stigation 28e P	lace of Injury -	At home, fa	arm. street	, factory, office b	uilding, et	tc. 28	3f. Location	(Street and Numb	er or Rural	Route Number, City
Division of Vital Records, tal or Attending Physician: The law requires after death.  In Director: After this certificate has been seled in by the funeral director, page 2 should be a selector.	Certification;	3 Suicide		ld not be symined (Spec				, , ,	0,		or Town,			
ing ing ing		4 Homicide 29a Certifier							4					
	cal	(Check pply	Certifying P	hysician: To the iminer:On the bas	best of my kno- sis of examinati	wledge, de: on and/or i	ath occurre	ed at the time, da on, in my opinion	ate and pia i, death oc	ace, and di curred at t	ue to the cau he time, date	use(s) and manner e and place, and d	as started: Iue to the c	ause(s)
To the within To the Complet	Medical			and mann	er stated			29c Licens				29d. Date sign		
	ž	29b. Signature and	title of certifi		IN									Day, rear)
		This	a Dio	usell	NUY			O.C.	IVI.□.			July 16, 20	00	
		30. N me and add												
		Melissa Bra			Medical Exa	100	111 Pe	enn Street, E	Baltimor	e, MD 2	1201			
	tate		nth, Qay Year	<b>9 2006</b> 32	Redistrar's Sig	gnature	No.	will !						
Reais		3		1	AT AND ASSAULT OF THE PERSON ASSAULT	-	1							

		1 - For State Registrar	State of Maryla		nent of Healt cate of Dea		ntal Hygie	4000	231	74				
Physicia		1. Decedent's Name (First, Middle, Last, £ LI ZABE7+		Smith		2	. Date of Death Month	Day Year 7 2006	3. Time of 4:30	Death M				
/Medic Examin		4a. Facility Name (If not institution, give	Street and number) BERT ST	4b.	City, Town, or Location  19657  Under 1 Year   If Un	OWN	July	4c. County of Death	iton					
Funeral Director			M 201 F 62	Mo	nths Days Hou	irs Min.	Date of Birth (Month, Day, Ye	9. Birth	place (State of	r Foreign				
death with the Maryland ms 23a or 28a-t ehow	ctor	10a. State 10b. County  Md. Washu		city, Town or Location					0d. Inside Cit					
th with th	Funeral Director	10e. Street and Number 62 EUZABE	tit St.	10	of. Zip Code 2/14	0	10g.	Citizen of What Cou	ntry?					
efter or ite	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Decedent of Hispanic s, specify Cuban, Mex es 21 No Spec		ly Yes or No- can, etc.)	14. Race - Americ Black, White, Specify: BL						
within ene. than	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12)	cation e completed) College (1-4or 5+)	(Give kind life. DO N	s Usual Occupation of work done during i IOT use retired)	_	'	o. Kind of Business/In	dustry M.B.	r				
ould be filed Mental Hygi erkad other	To Be C	17. Father's Name (First, Middle, Last)  George V.	First, Middle, Mai Andc	euson										
s 1 and 2 should if Health and Men item 27 is marks other traumatic			Pushia (clau)	62 64	12AB691	ST H	agerst	£.1.14	2174	10				
rmit. Page partment o portant: If y injury or		20a. Method of Disposition  1	ternoval from State	Place of Disposition cemetery, cremator  COSC HILL  22. Nai	y or other place)	July 15 acility S FE	12006	Huyersto Home	wn M					
Physician		21. Signature of Funeral Service Licensee  22. Name and Address of Facility  23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Immediate Cause (Final disease or condition  Cerebral  Cerebral  Approximate Interval Between Onset and Death												
/Medical Examiner	70	resulting in death)  Sequentially list conditions, if any, leading to immediate	Due to (or as a conse	to to (or as a consequence of):  Renal Failure  to (or as a consequence of):  Diabetes melitus										
cate be executed by sicien and the burial-transit	cai Examine	Cause (Disease or injury that initiated events resulting in death) Last												
death certifii e ettending I d for use as	hysician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	3c. If yes, outcome of preg 1 □Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown	23d. Date of delivery Month Day Year										
w requires that the been signed by the should be detache	by P	Part II. Other significant conditions con	ntributing to death but not re	co use contribute to the cause of death?										
The lav	Completed						24a. Was an autopsy performed		psy findings a npletion of ca 2 No	ivailable iuse of				
ysician: The	o Be	25. Was case referred to medical examiner?	lospital:	7500		lace of Death (C								
ding Phy h. After this funeral d	1-1	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	me 5 Nesidence 6 ⊡Other (Specify) 28d. Describe how injury occurred								
To the Hospitel or Attending Physician: within 24 hours after death.  To the Funerel Director: After this certifical completely filled in by the funeral director;	Certification:	2 Suicide 6 Could not be						28f. Location (Street and Number or Rural Route Number, City or Town, State)						
To the Hospitel or At within 24 hours after of To the Funerel Directompletely filled in by	edicai C	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.												
To th withir To th comp	Me	29b. Signature and title of certifier	29d.	29d. Date signed (Month, Day, Year)										
4		30. Name and address of person who co		em 23a) (Type, Print	0060		in ct	n MD	2174	+0				
Sta Registr		31. Date filed (Month, Day, Year)	32. Projistrar's Sign	nature &	6)	7								

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 15° July 2006 Peter Stavrakis 1649 Рм /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Ceci1 Union Hospital E1kton If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, 1) March 12, 7. Age (In yrs. last birthday, Birthplace (State or Foreign Country) **Funeral** Months 10XM 2□F 220-44-3069 89 Director Ukraine Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10a. State 10d. Inside City Limits 23a or 28a-f show the Medical Exactinar must be notified at 1 X Yes 2 ☐ No Director Delaware New Castle Newark 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 186 Elkton Road 19711 United States Pages 1 and 2 should be filed within 72 hours after death vant of Heelth and Mental Hygiene.
ant: if flean 27 is marked other then "naturel; or theme 23, ury or other freumatic event, it a Medical Exact natural ury or other freumatic event, it a Medical Exact natural. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 (Ži No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify Specify. 3 Widowed 4 Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Physician Medical 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Stelianos Stavrakis Kathryn Farimskaya 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Helen Stavrakis/Wife 186 Elkton Road, Newark, Delaware 19711 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) July 17, 20c, Location - City or Town, State West Chester, 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State pernit. Page Department o Importent: If any injury or once. R.A. Ferris & Co., Inc. 2006 4 ☐ Donation 5 ☐ Other (Specify) Pennsylvania 21. Signature of Funeral Service Licensee 22 Name and Address of Facility Hicks Home for Funerals, P.A. 103 W. Stockton Street, Elkton, Maryland 21921 maid 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Betw Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of) 2000 /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of). Examine or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760, Medical Certification: To Be Completed by Physician/Medical page 2 should be detached for use as the 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown á Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy certificate 1 🗌 Yes 2 No 2□ No 1 Tyes within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director. 25. Was case referred to medical examiner? 26. Place of Death (Check only one, Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Yes 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 3 Suicide 6 Could not be 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide o the Hospitei Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 7/18-2006 11M1 pleted cause of death (Item 23a) (Type, Print) 23 DO IMO 31. Date filed (Month, Day, Year) legistrar's Signature State 2 4 2006 Registrar

	1	For State Registrar	State of Mary		partment of F ertificate of		R	eg. No.	16	23176	
Physicia	ın	1. Decedent's Name (First, Middle, Last Gladys A.	)	Swange	er		2. Date of Dea Jul 18, 2		Year	3. Time of Death 8:50 am M	
/Medic Examin		4a. Facility Name (If not institution, give Allegany County Nu	street and number)		4b. City, Town, o	or Location of Death		4c. County of Allegar			
Funeral Director		5. Social Security Number 6. Se 220–10–7779		n yrs. last birthd	Months   Davs	If Under 24 Hrs. Hours Min.	Jun 26,	1920	9. Birthp	lace (State or Foreign try)	
a-f show		Usual Residence of Decedent  10a. State 10b. County  MD Allegan		Cun	nberland					0d. Inside City Limits 1    Yes 2   No	
3a or 28	al Dire	10e. Street and Number 15125 Mt. Laurel La		10f. Zip Code	21502		10g. Citizen of W US		try?		
is 1 and 2 should be filed within 72 hours after death with the Maryland of Health and Membral Hygiene.  If Health and Membral Hygiene.  Other traumatic event, the Medical Examinational be notified at	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	er in U.S.	13. Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☐ No		pecify Yes or No- Rican, etc.)	Blaci	k, White,	- American Indian, , White, etc. <b>White</b>	
within 72 ho ene. than *natura	Completed	15. Decedent's Ed (Specify only highest grad Elementary/Secondary (0-12)	ucation de completed) College (1-4or 5+)	(G lit	ecedent's Usual Occup Bive kind of work done le. DO NOT use retire emaker	ccupation one during most of working attred)  16b. Kind of Business/Industry own home					
should be filed within and Mental Hygiene. marked other than matic event, the Maria	To Be Co	17. Father's Name (First, Middle, Last)  Calvin Mummert		,		Martha	Tyson V	lummert			
and 2 shou alth and N 127 is mai		19a. Informant's Name/Relationship (7 Shirley Bible	daugnt		lailing Address (Street O New York	t and Number or Ru Avenue				A 15074	
Pages 1 au nent of Hea ant: If Item arry or othe		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ 14 ☐ Donation 5 ☐ Other (Specify	Removal from State	20b. Place of D cemetery, Davis Mer	isposition (Name of crematory or other planal Cemeter Company)	ery	7/20/2006	Cumber	*	MD	
permit. Pages Department of Important: If It any Injury or once.		21. Signatur of Funeral Service Licen	nell	1		ginia Avenue	e; Cumberl		1502		
Physician /Medical		23a. Pan 1. Enter the disease, or corn shock or heart failure. List only disease or condition resulting in death)	a.  Due to (or as a co	afic	Carcin	ing, such as cardiac	or respiratory ar The (	slon.	L	Approximate Interval Between Ondet and Death	
Examiner	er	Sequentially list conditions b.									
icate be executed physician and sthe burial-transit	ıl Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a c	consequence of)	:				-		
death certil	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ► No 9 □ Unknown		23d. Date of delivery  Month Day Year							
ires that the signed by		Pary Thother significant conditions of	ontributing to death but	not resulting in the	he underlying cause gi	iven in Part I.	23e. Did to	_		he cause of death?	
VICAL MECOLOS, P.O. sicien: The law requires that the certificate has been signed by the rector, page 2 should be detach	Completed by			5			24a. Was autop perfo	rmed?		opsy findings available impletion of cause of	
	o Be C	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital: 1 ☐ Inpatient	2 ER/Outp	atient 3 DOA	thor .	ath (Check only o	ine)			
UNISION OF VICA To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific.	100	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day)		ne of 28c. Injury		,	now injury occurr		,,	
DIVISION OF  It or Attending Phy after death. Director: After this d in by the funeral of	Certification:	3 Suicide 6 Could not b 4 Homicide determined	n, street, factory, office	•	Street and Numb vn, State)	t and Number or Rural Route Number, late)					
DIVI To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	edical C	29a. Certifier (Check only one)  1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.									
To the within To the compli	Me	29b. Signature and title of sertifier	han_		D19	750		29d. Date signed			
5		30. Name and address of person who V.A. Ranjithan		Fur	rnace Stree	t Ext. Cum	berland	MD 2450	02		
Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Registrar	's Signature	Crarles						
DHMH 17 Rev 1/2	2001	JUL 2 1 20		ORIG	INAL						

State of Maryland / Department of Health and Mental Hygien® For State Registra Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** July 15, 2006 5:30 P. Steven Allen Swope /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** 229 N. Locust St. Apt. Washington Hagerstown If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1**X** M 2□ F Yrs. 217-56-0007 July 12,1952 Director 54 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or Items 23s or 28e-f show the Medical Examiner must be nutified at 1 XYes 2 No Director Md. Washington Hagerstown 10g. Citizen of What Country? 10e, Street and Number 10f. Zip Code 229 N. Locust St. Apt. 3 21740 U.S.A death v Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 230 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or Item any injury or other treumatic event, the Mentals. 1 Never Married Married Baltimore, Maryland 21215-0036 1 Yes No Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced Completed 15 Decedent's Education 16a, Decedent's Usual Occupation 16b Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Laborer Warehouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Clyde H. Swope Connie Sisk 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Linda L. Swope (Wife) 229 N. Locust St. Apt. 3 Hagerstown, Md. 21740 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State July 18, 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Smithsburg Crematory Smithsburg, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 12525 Bradbury Ave. J.L. Davis Funeral Home Smithsburg, Md. 21783 M01414 LAVIS Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. METASTATIC Immediate Cause (Final CANCELTO LANYAX, FINE, LUNG Physician disease or condition resulting in death) 6 MONZIES /Medical Due to (or as a consequence of) Examiner Primary Lawrectest

Due to (or as a sinsequence of ... Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner The law requires that the death certificate be executed ettending physicien and for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the eld be detached f 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Unknown icate has been sig , page 2 should b Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No certificate 1 Yes To the Hospitel or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) Certification: 27. Manner of Death Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Yes 2 No death. Director; / 2 Accident investigation 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide 24 hours a Funeral I 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Madical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) the state within 2 To the 29c. License number 29d. Date signed (Month, Dev. Year) 29b. Signature and title of certifier D005139 anto 3 30. Name and address of person who completed Jause of death (Item 23a) (Type, Print) M.O. 11110 MEDICA CAMPOS Rg. WILLIAM E. RO 31. Date filed (Month, Day, Year) 32. egistrar's Signature State

DHMH 17 Rev 1/2001

Registrar

2 1 2006

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death 1 Decedent's Name (First Middle Last) 2. Date of Death **Physician** CHARLOTTE SHROM JULY 2006 ANN 16 1:05 a<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Chestertown Nursing & Rehab Chestertown Kent If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 X F 189-34-2234 Yrs. Director 65 Pennsylvania 1940 Usual Residence of Decedent the Maryland 10a State 10h Counts 10c. City. Town or Location 10d. Inside City Limits 28a-f show treumatic event, the Medical Examinar must be notified at MD Queen Anne's Chestertown 1 ☐ Yes 2 ☑ No by Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5 142 Longfellow Dr. 238 21620 U.S.A. or items 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 ☑ No Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed withIn 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 21 No If Yes, Give Specify: Specify: White 3 Widowed 4 □ Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 7. Department of Health and Mental Hygiene. Importent: If Itam 27 is marked other than "ne any injury or other treumatic event, the Martagones. Elementary/Secondary (0-12) College (1-4or 5+) Bartender 11 Bar/Pub 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel Pickrell Alice Ransom 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) John P. Jones (companion) 142 Longfellow Dr. Chestertown, MD. 21620 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State Still Pond Cemetery 7/19/06 4 ☐ Donation 5 ☐ Other (Specify) Still Pond, MD. 21. Signature of Juneral Service Lice 22. Name and Address of Facility
Galena Funeral Home of Stephen L: Schaech M00510 118 West Cross St. Galena, MD. 21635 Party Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in dilath) CARDIO PULLIONARY Priysician /Medical Due to (or as a consequence of): Examiner Bronclugenie Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner tobacco ABUSE Due to (or as a consequence of) Box 68760. Physician/Medical The law requires that the death certificate IF FEMALE: 23c. If yes, outcome of pregnancy
1□Live birth 2 □ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No Day 4 Pregnant at time of death 5 Other (specify) ed by the detached 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 2 Division of Vital Records. 1 ØYes 2 □ No 3 □ Probably 4 □ Unknown Be Completed been 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death? certificate 2□ No 2 No 1 Yes 1 Tyes ierel Director: After this certific filled in by the funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☑ No Certification: To 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred or Attending 1 Natural 5 Pending investigation Injury death. 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Thomicide within 24 hours a To the Funerel L 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License numbe 123889 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 223 High St. Arrabal, John C. M.D. Chestertown, MD. 31. Date filed (Month, Day, Year) 32. Figistrar's Signature State JUL 2 1 2006 Registrar 18-2.00

			1 - For State Registrar	State of M	aryland		artmer rtificat			ınd M		iene	106	23179		
	Physic /Medi		Decedent's Name (First, Middle, Last)  Alverta W. Torney								2. Date of Deat Month	h Day ul 7, 200	Year 6	3. Time of Death		
	Examir		4a. Facility Name (If not institution, give Calvert County	e street and number) ty Nursing Center			4b. City, Town, or Location of Death Prince Frederic				4c. (		County of Death Calvert			
	Funeral Director		213-74-1732	x 7. Ag	ge (In yrs. Ia 100	ast birthday) Yrs.	If Under Months		If Under 2 Hours	24 Hrs. Min.	8. Date of Birth (Month, Day, Apr 8	Year) , 1906	9. Birth Cou	Birthplace (State or Foreign Country)     Maryland		
Baltimore, Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland	Maryland a-f ahow	tor	Usual Residence of Decedent  10a. State 10b. County  MD Cal	vert	10c. City	, Town or Lo	ocation							10d. Inside City Limits 1 ☐ Yes 2 ☐ Xo		
	h with the	al Director	10e. Street and Number 11184 Millbridge Road					10f. Zip Code 10g.					. Citizen of What Country? U.S.A.			
	ours after deat ral', or itama ? Examinar mu	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	1 □ Vas 2 □ No		Was Decedent of Hispanic Origin? (Specif Yes, specify Cuban, Mexican, Puerto F  1 Yes 2 No Specify:  dent's Usual Occupation kind of work done during most of workin DO NOT use retired)  Domestic					ack, White,	Ame <i>r</i> ican Indian, White, etc. <b>Black</b>				
	od within 72 h gjene. er then "netu . the Medical	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	ducation de completed)  College (1-4or 5+)  16a. Decec (Give life. L					ng			dustry Ise's Home				
	ould be file Mental Hy arked oth atic avant	To Be (	17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sur													
	and 2 she laith and 27 ia m er traum		19a. Informant's Name/Relationship (Ty. Agnes Bean/daughter	pe, Print)					nd Number by, MD		l Route Number, 7	City or Town	n, State, Zip	Code)		
imore	Pages 1: nent of He ant: if itan ury or oth		20a. Method of Disposition 1 ☐Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	20b. Pla	ace of Dispo metery, crer St. John	natory or o	ther place	· 1		/13/06	0c. Location	- City or To			
Balt	Departi Departi Importi any inj		21. Signature of Funeral Service Licensee  22. Name and Address of Facility Sewell Funeral Home 1451 Dares Beach Road Prince Frederick, MD 2							, MD 20	678					
E	Chysician and physician and physician and physician and stree private transit street private transit street physician and physician and physician and physician and physician and physician physicia	dical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):										Interval Between			
	death certif e ettending id for use a	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ M6 9 □ Unknown	Was decedent pregnant in the past 12 months?  1 Yes 2 Not   23c. If yes, outcome of pregnancy 1 Fetal death 3 Ectopic pregnancy 5 Other (specify)									23d. Date of delivery Month Day Year			
	w requires that the been signed by th should be detache		Part II. Other significant conditions con	II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contributing to death but not resulting in the underlying cause given in Part I.									/			
Rec	The law ate has b page 2 st	e Completed	25. Was case referred to medical								24a. Was an autopsy perform	ed?	prior to cor death?	psy findings available inpletion of cause of		
<u> </u>	9 0 1	To Be	examiner?	Hospital: 1   Inpatient 2   ER/Outpatient 3   DOA   Other: 4   Nursing Hon							h Check only one) me 5 ☐ Residence 6 ☐ Other (Specify)					
ion of	ding h. After fune		27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju	3					<u>/</u>						
Divis	Dir	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)					28f. Location (Street and Number or Rural Route Number, City or Town, State)							
	A Hospital 24 hours a Euneral I letely filled	edical											ated. the cause(s)			
)	To the within 2 To the complet	Me	29b. Signature and title of certifier  Ska	MD			i	License	number	0	29	d. Date signe	ed (Month, I	Day, Year)		
	4		30. Name and address of person who co	mpleted cause of d	eath (Item 2	23a) (Type, I	Print)	RD		Poi	nu f	red	MD	20678		
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registr			do	de						U		

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death July Day 2006 Year **Physician** 3, THYS JANINE ELISE JULIENNE 12:10P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Montgomery 8809 Ouiet Stream Court Potomac | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month Pay, Year) | Aug. 15, 1931 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1□M 2₩F Belgium 74 212-64-7177 Yrs Director Usual Residence of Decedent the Maryland 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits Worle r than "natural, or iteme 23a or 28a-1 ehor the Medical Examinar must be notified at 1 TWes 2 No Director Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20854 U.S.A. Pages 1 and 2 should be filed within 72 hours after death inent of Health and Mental Hyglene.
ant: if item 27 ie marked other than "natural", or iteme 23airy or other traumatic event, the Medical Examinal matal. Completed by Funeral 8809 Quiet Stream Court 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 32 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Eurenco Elementary/Secondary (0-12) College (1-4or 5+) Consultants Secretary lvr 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Marietta Van Haelen Georges Vanden Bussche ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8809 Quiet Stream Ct Potomac, MD 20854 Alain Thys- Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Department of He Important: if Item eny injury or oth once. 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from 7/5/06 Metr Fnrl Svcs Alexandria, VA 4 □ Defiation 5 □ Other (Specify) 22. Name and Address of Facility Snowden Funeral Home, PA 21. Sign of Funeral Service Lice 246 N. Washington St Rockville, MD20850 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final Physician METASTATIC BREAST CANCER 2 Years disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) anding physician and use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of defivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) been signed by the should be detached 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has birector, page 2 s nerio 1 ☐ Yes 2 No 1 Yes or Attending Physician: director, 25. Was case referred to medical Be 26. Pface of Death Check only one Hospitaf: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) ဥ 1 ☐ Yes 2 ☐ XNo Sign Sign After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation death. 1 Yes 2 No 2 Accident Director: , in by the f 3 ☐ Suicide 6 Could not be 28e. Place of fnjury - Af home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a
To the Funerai I
completely filled the Hospitai pelli Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai (Check only one) 29b. Signature and little of certifie 29c. License number 29d. Date signed (Month, Day, Year) D33293 July 7, 2006 12 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)
Mr. Frederick P. Smith, MD 5454 Wisconsin Ave #1300 Chevy Chase, MD 31. Date filed (Month, Day, Year) 32. Regisfrar's Signature State 10 2006 Registra

State of Maryland / Department of Health and Mental Hygiene 0 0

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	er de	Funeral	11. Marital Status	12. Was Decedent Ever in Armed Forces?		Was Decede If Yes, speci	fy Cubar	spanic Orig n, Mexican,	Puerto Ri	fy Yes or No- can, etc.)			- Americ , White, (		
36	be filed within 72 hours after death with the Maryland stal hygiene. ed other than "natural", or Itama 23a or 28a-f ahow avant, Ita Micdical Examinat must be notified at	by F	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 ☐ Divorced	1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2	No	Specify:				Specify:	D1 no	-1 <sub>-</sub>	
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Maryland	hental ked o	To B	Will Thomas			•		Selma	Chris	tian					
ary	2 should be and Mental ia marked i	_	19a. Informant's Name/Relationship	(Type, Print)	19b. Mailir	ng Address	(Street a	nd Numbe	r or Rural F	Route Numbe	r, City o	or Town, S	State, Zip	Code)	
Σ	alth a	1 3	Sandra B. Marshall	/ daughter	1825 E	Billman	Lane	Silv	er Sor	ing, MD	2090	12			
re,	E B B B		20a. Method of Disposition		Place of Dispo	sition (Name	e of	CI - Hilliam	Dat			ocation - (	City or To	wn, State	
Ē	Page Int. T		1 ☐ Burial 2 【Cremation 3 4 ☐ Donation 5 ☐ Other (Spec		etropolit	,		1	uly 9,	2006	Alex	kandri	a. VA		
Baltimore,	mit.	- 1	21. Signal re if Funeral Service Lic		22	2. Name and	Addres:	s of Facility	/				٠., ۱		
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o.	the de	Physician	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐ Unknown	dea(ii 5)	Other (spe	rcity)								
٥.	The law requires that the death ate has been signed by the atter page 2 should be detached for u	H.	Part II. Other significant conditions	contributing to death but not re	esulting in the u	nderlying ca	use give	n in Part I.		23e. Did to	bacco u	use contri	bute to th	e cause of de	eath?
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Division of	Attending or death.	fica	3 ☐ Suicide 6 ☐ Could not	be 28e. Place of Injury - At	home, farm, str	eet, factory,	office		28	f. Location (S			r or Rurai	Route Numb	oer,
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	To the Hospitel or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the	edical	(Check only 2 Medical Exone)	aminer: On the basis of exami and manner stated.	nation and/or in	vestigation,	in my op	inion, deat	n occurred	at the time, o	jate and	place, a	nd due to	the cause(s)	
	To the within 2 To tha complet	Σ	29b. Signature and title of certifier	10.		29c.	License	number		-	29d. Da	te signed	(Month, L	Day, Year)	
4	L		) (!HTQ	tere os			10733	L			July	7, 20	006		
/			30. Name and address of person wh	o completed cause of death (It	ет 23а) (Туре,	Print)									
			Christian Lefevre, M			, Washi	ngtar	n, DC 2	20037_						
	Sta Registi		31. Date filed (Month, Day, Year)  JUL 10	2006 32. Pegistrar's Sig	Lo A	resti 1									
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#### 06-04673 Julian S. Tyson

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Rea No Registrar Decedent's Name (First, Middle Last) 2. Date of Death Phỳsician/ Month D July 3, 2006 1714 hrs S. Tyson Julian Medical Examiner 4b. City, Town, or Location of Death 4a Facility Name (if not institution, give street and number) 4c. County of Death Capitol Heights Prince George's 1311 Opus Avenue 8 Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 7 Age (In yrs. last birthday) 5 Social Security Number 6. Sex **Funeral** Foreian Days Hours Months August 21,1966 Director 39 Country) Washington. 577-82-2950 1X M 2 Usual Residence of Decedent 10d Inside City Limits 10c. City, Town or Location 10a State 10b. County 1 X Yes 2 No Washington DC None with the Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 20032 United States 439 Orange Street SE 14 Race - American Indian, Black, Funeral 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-11 Marital Status If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces' death v 1 X Never Married 2 Married Yes Specify Black Yes 2 X No specify Widowed 4 Divorced f Yes. Give Year 'natural", \$ 16b Kind of Business/Industry 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use relired) 15. Decedent's Education (Specify only highest grade completed) Completed Walter Reed Army Elementary/Secondary (0-12) College (1-4 or 5+) permit Pages I and 2 should be filed within 72 pepartment of Health and Mental Hygiene Important: If iten 27 is marked other than " injury or other traumatic event, the Medical. Medical Center MD 21215-0036 12th Boiler Operator 18.Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Velma Johnson Richard A. Tyson Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) Velma J. Johnson (Mother) 1311 Opens Ave. Capital Heights, MD 20743 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a. Method of Disposition Baltimore, permit. Pages I and Department of Heal crematory or other place' 1 XBurial 2 Cremation 3 Removal from State 7/15/06 Washington, DC Mt. Olivet Cem. Donation 5 Other Specify 22. Name and Address of Facility Austin Royster Funeral Home 21. Sign Unit of Funeral 3821 14th Street NW Washington, DC 20011 ter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock Physician List only one cause on each line. Disseminated crytoccosis associated with Between Onset and /Medical Death a Acquired immune deficiency syndrome Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of) of any, leading to immediate cause. Enter Underlying Cause Examine (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): ď and Physician/Medical AMENDED item#23a,27,perme, G859,9/27/06 TT #10cperFH7/18/06.BMW.McCo X UNPENDED physician the burial -Box 68760, 23d Date of delivery IF FEMALE 23c. If ves, outcome of pregnancy 23b. Was decedent pregnant in the Year 3 Ectopic pregnancy Month Day Fetal death attending past 12 months? Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Records, P.O. þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b Were autopsy findings available autopsy prior to completion of cause of performed? death? ✔ Yes 2 No 1 🗸 Yes 26. Place of Death (Check only one) 25. Was case referred to medical the Hospital or Attending Physician: Division of Vital Be Other<sub>4</sub> Hospital: 1 ER/Outpatient 3 Nursing Home 5 Residence 6 V Other: Scene Inpatient After this 1 🗸 Yes 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c Injury at Work? 28d. Describe how injury occurred 1 X Natural Yes 2 No 5 Pending the f 2 Accident 28e Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be 3 Suicide or Town, State) determined 4 Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started ica 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2. To the F and manner stated 29c License number 29d Date signed (Month, Day, Year) Signature and title of certifier O.C.M.E. July 4, 2006 Malynee 30 Name and address of person who completed cause of death (Item 23a) Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD.

DHMH 17 Rev 1/2001 OCMF 2006

State

Registrar

31. Date filed (Month, Da

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Registrar's Signa

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			1 - For State Registrar	State of Marylan		artment of			Reg. No.	21116	23183
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	/Medic	al		e Thibault		# C' T-			200		8:30 A M
	Examin	er	4a. Facility Name (If not institution, give	•		Salis	n, or Location of D	eath		County of Death	
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	ath w	rai	1003 Adams Ave.,			2180			US		
	r Item	Completed by Funeral Director	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U Armed Forces? 1 ☐ Yes 2 🕅 No				? (Specify Yes or Numerto Rican, etc.)		4. Race - Americ Black, White,	etc.
8	ral', o	d by	3 ☐ Widowed 4 🛣 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🖾 i	No Specify:			Specify: Whit	e
5-0	72 h	etec	15. Decedent's Ed (Specify only highest gra	ducation ide completed)	16a. Dece (Give	dent's Usual Oc kind of work do	cupation one during most of tired)	working	16b. Kin	d of Business/In	dustry
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Baltimore, Maryland 21215-0036	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23e or 28e-f show any Injury or other traumatic event, the Medical Exeminar must be neitling at ance.	To B	Aimee Edgar Th	ibault			Josep	hine Aulo	d		
Jar	2 short and 1 sm.		19a. Informant's Name/Relationship (	Type, Print)	1	-		Rural Route Numb	-		Code)
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nor	ages ant of it: If it y or o		1 ☐ Burial 2 🖾 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification Specification Specif	Removal from State	emetery, crei	natory or other	<sub>Place)</sub> Crem. 7-	11-06		kford, [	
alt:	mit. Poertme portan Injur		21. Signature of Funeral Service Licer		ipe ner	Name and Ad	Idress of Facility	The Burba	age Fi	ineral E	lome
ă	Depermine Depe		/ Tassueline	1 Dasterty		108 Wil	lliam St.	, Berlin	, Md.	21811	
)	Physician /Medical		23a. Part1. Enter the disease, or con- shock, or hear failure. List only tmmediate Cause (Final disease or condition resulting in death)	a. Huntington's	Disea		dying, such as car	diac or respiratory a	arrest,		Approximate Interval Between Onset and Death 10 yrs.
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8760,	icate be executed physicien and s the burial-transit	Ical Examiner	resulting in death) Last	Due to (or as a conseq	uence of):						
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Division	l or Atte after des Directo s in by th	Certification:	3 ☐ Suicide 6 ☐ Could not b 4 ☐ Homicide determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, str y)	eet, factory, offi	се	28f. Location ( City or To	Street and wn, State)	Number or Rura	d Route Number,
	To the Hospitel or Attending F within 24 hours after death. To the Funerel Director: After completely filled in by the funer	Medical C	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exar	ysician: To the best of my kno niner: On the basis of examina and manner stated.	wledge, deatl tion and/or in	n occurred at the vestigation, in m	e time, date and pl ny opinion, death o	ace, and due to the ccurred at the time,	cause(s) a date and p	and manner as solace, and due to	lated. the cause(s)
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	- i.L		30. Name and address of person who			Print)		03033			
5	Sta	to	Glenn Arzadon, M. 31. Date filed (Month, Day, Year)	U. 9/14 Healt 32. Pegistrar's Signa	nway L	Jr., Ber	riin, Md.	21811			
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State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 5\_\_ 2:04P M JULY 2006 ELAINE THOMPSON /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner FREDERICK MEMORIAL HOSPITAL FREDERICK FREDERICK # Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year)

Bayes Hours Min. 3, 28 - 48 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex **Funeral** 217-42-9392 58 Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location e filed within 72 hours after death with the Marylar al Hygiene, in the contract of the contract of the contract of the contract of the contract of the contract of the went, the Medical Examinat must be notified at FREDERICR 1 Yes 2 No MD FELOGEICK Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? EATHERIDGE DR. UNITH 750 21702 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 1 No Saltimore, Maryland 21215-0036 Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) IN SURA WCE Elementary/Secondary (0-12) College (1-4or 5+) PAYROLL DATA TECH. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Peges 1 and 2 should be fill ment of Health and Mental H lant: If Item 27 Is marked oth Mompson CLAYTON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Z \$213 DAU 8211 UNIVERSITY RIDGE DR. ADT 103 CHARLOTTE N.C. R. THUMPSON TIFFANIY 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Peges
Depertment of
Important: if it
eny injury or c 1 Burial 2 Cremation 3 Removal from State 1206 FRED. RESTHARM Mon. GAL. JULY 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Fundant item &
SAME TOWNS ST PRODUCT 21. Signature of Funeral Service Proenses GARY L POURS y 21701 Muy MO 23a. Part1. Enter the/disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Artery Disease **Physician** oronary disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner physicien and s the burial-trans resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical use as the *IF FEMALE:* 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 🗷 No detached 9 Unknown 9 Unknown signed by I Part fl. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? by Hypertension 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? page 2 s has autopsy performe 1 ☐ Yes 2 ☐ No 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No ۵ 3□ DOA 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 5 ☐ Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident efter death 3 Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of fnjury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours To the Funerel 29a. Certifier 1 💆 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MP July 6, 2006 D0058726 30. Name and address of person who completed cause of death (frem 23a) (Type, Print) 3000-D Ventrie Ct, Myersville MOZITT3 Parkview Medical Yvette Warren MD 31. Date filed (Month, Day Year) strar's Signature 32. R State Registrar

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink., Ensure All Copies Are Legible.
AMEND TTPM/25, perDVR, G057, 7/24/00, WS
State of Maryland / Department of Health and Mental Hygiene - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death - 2006 **Physician** Clyde Thomas Donald /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner Allegany Cumberland 1201 Virginia Avenue If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, May 16 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Min. 1**⋈** M 2□ F Months Days Hours 62 219-44-0918 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County or items 23s or 28s-f show the Medical Examiner must be notified at Allegany Cumberland MD 1 □Xes 2 □ No Directo 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number USA 21502 1201 Virginia Avenue Be Completed by Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Mes, Give Year or Dates: 1962-9 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 Yes 2 No Maryland 21215-0036 Specify Specify: white 3 Widowed 4 Divorced "natural", 1962-91 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) 12 Warehouse Manager Warner's Hearth and . Pages 1 and 2 should be filed w iment of Health and Mental Hygis tant: if Item 27 is marked other t ijury or other traumatic event, ID. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Martha E. Thomas unknown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) MD 21502 Cumberland 21 Arch Street Donnie Thomas Jr. son Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 XBurial 2 Cremation 3 Removal from State permit. Page Department o important: if any injury or 7/18/2006 MD Rocky Gap Veterans' Cemetery Flintstone 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licens 22. Name and Address of Facility
Scarpelli Funeral Home, P.A. 108 Virginia Avenue; Cumberland, MD 21502 23a. Pant. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, br heert failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Gause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a conseque Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Qualto (or as a consequence of) Examine attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): P.O. Box 68760. Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 ☐ Yes 2 No 1 ☐ Yes 2 ☐ No After this certificate or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) TETTES 2 No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 5 Pending investigation 1 XNatural 1 ☐ Yes 2 ☐ No within 24 hours after death.

To the Funeral Director: A 2 Accident the 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) à 4 Homicide pellil the Hospitei 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D54411 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of 31. Date filed modify Day Yaar 2006 Registrar's Signature 500 Memorial Ave Ste 105 Cumberland MD 21502 State Town.

Registra

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend #8 per FH 7/10/2006State of Maryland / Department of Health and Mental Hygiene 1- State AACO Health lo Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Year **Physician** CHARLOTTE VOGELSANG 7:02 AM MAY 2 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner HOSFITAL BALTIMORE HARBOR If Under 1 Year | If Under 24 Hrs. 8. Date of Birth 5/22/1913. Birthplace (State or Foreign (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Months Days Hours Min 1 □ M 2 🗙 F Yrs. 89 Director 577-20-9853 May 20, Ohio Usual Residence of Decedent filed within 72 hours after death with the Maryland Hygiene.
Hyane 13s or 18e-1 show 10c. City. Town or Location 10b. County 10a. State 10d. Inside City Limits ral', or Items 23s or 28e-fahow Exa⊤iner must be notified ⊯ MD Pasadena Anne Arundel 1 ☐ Yes 2 XNo Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 21122 30 Margaret Road Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 ☒ No Specify: 3
☑ Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Home 12 and Mental Hygie Is marked other permit. Pages 1 and 2 should be file Department of Health and Mental Hy, Important: If item 27 Is marked oths any injury or other traumatic avent, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be C. Pauline Evans Harold King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pasadena, MD 21122 Richard Vogelsang/Son 30 Margaret Road 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition July 7, 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Glen Haven Cemetery 2006 Glen Burnie, MD \* 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Barranco & Sons, P.A. Severna Park Funeral Home ( Da 495 Gov. Ritchie Hwy. Severna Park, MD 21146 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final CONFESTIVE **Physician** HEART FAILURE 75 years disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Atrial FIBRILLATION 75 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, attending physician Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 14 No Month Year Day 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ CHRONIC OBSTRUCTIVE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown FULMONARY DISEASE Completed PNEUMONIA 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a, Was an 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No ٩ in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide within 24 hours a To the Funaral D 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Cartifier Medical and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month. Day, Year) RESUUI M.O. July 2, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DHMH 17 Rev 1/2001

State Registrar

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31. Date filed (Mo

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. Registrar's Signature

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100				Mary's Hospita	7. Age (In yrs	last highday)	ff Under 1 Year	Leonardtowr				
	Funeral Director		5. Social Security Number 217-46-8853	6. Sex 1 ☐ M 2 ☐ F	62 62		Months Days	Hours Min.	8. Date of Birth (Month, Day, 1 May 16	(ear) 1944	Coun	lace (State or Foreign try) Maryland
	and and		Usual Residence of Decedent  10a. State 10b. Count	у	10c. C	ity, Town or Lo	cation				1	0d. fnside City Limits
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	with the	Dire	10e. Street and Number 252 Fairground Roa	d			10f. Zip Code	20678	10	g. Citizen of V	hat Coun U.S.	
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and 2	be filed htal Hygid od other event, I	Be	17. Father's Name (First, Middle	John H. V	Vallace, Si			18. Mother's Nam	e (First, Middle, Mi Mary B	aiden Sumam eatrice M		
Maryland 21215-0036	nd 2 should lath and Meniallh and Menialher	ဥ	19a. Informant's Name/Relation Lucille Wallace/wif	iship (Type, Print)		19b. Mailin			ral Route Number, y, MD 20657	City or Town.	State, Zip	Code)
Baltimore, I	permit. Pages 1 am Department of Heall Important: If Item 2 any injury or other once.		20a. Method of Disposition  1 Burial 2 Cremation  4 Donation 5 Other (				sition (Name of natory or other plac Memorial Garde	θ)	Date 2	0c. Location -	City or To Dunkir	
Balti	permit. Pa Departmen Important: any injury	1 1	21. Signature of Funeral Service	a Licenseez	P	22	Name and Address Sewell F 1451 Da		e oad Prince F	rederick,	MD 20	678
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VIta	Physicien: Th r this certificate real director, pag	Be	25. Was case referred to medic examiner?	Hospital:			Oth	or	th (Check only one		(6	
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of	hys Lin	.T	1 ☐ Yes 2 ☐ No  27. Manner of Death	Hospital: 1 ☐ Ing 28a. Date of	patient 2 E	R/Outpatient 28b. Time of				e 5 Resid			(y)
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	the Houndin 24 h the Fur Tpletely	Aedicai	one)	niner: On the bas and manne	is of examination	on and/or inv	estigation, in r	my opinion, de	ath occurre	d at the time, c	ate and place,	and due to	o the cause(s)
	2 1 2 5	Σ	29b. Signature and title of certifier	7 Pela	, m	0		252	5		9d. Date signe		
			30. Name and address of person who	0 -		23a) (Type, F 670)	Print)  N- C	harl	4 St.	Bala	to md	21.	20%
	Sta	te	31. Date filed (Month, Day, Year)	00 32 dec	gistrar's Signatu	ire da	rette )						

	1	For AMEND#2 PE State Registrar 7/10/06					rtment of H tificate of I		i wentai ny	Reg. No.	2000	) 25	183
Physicia	1.00	1. Decedent's Name (First, M. BERNAD ET)	iddle, Last)						2. Date of D Month	eath 7/1	/06	3. Time of	
/Medica	al -	4a. Facility Name (If not institu		VILS and number)	000		4b. City, Town, or	Location of De	ath	4c. 0	County of Deat	-	SAM
	=1	Anne Arundel			er		Annapo	olis	1	Ar	ne Aru	ndel	
uneral rector		5. Social Security Number 214-44-1302	6. Sex 1 M 2		e (In yrs. last bir 60	thday) Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M	in. 8. Date of B (Month, D Dec. 1	ay, Year)	Co	hplace (State o untry) aryland	
3		Usual Residence of Decedent 10a. State 10b. Cou			10c. City, Town	n or Lo	cation					10d. Inside Ci	ty Limits
of sho	tor	MD Quee	n Anne's		Stev	ens	ville					1 ☐ Yes	2 <b>N</b> o
or 28a	Director	10e. Street and Number					10f, Zip Code			10g. Citiz	en of What Co	untry?	
s 23a	rait	101 Trequass		- D	E	1 10 11	2166		(Consider Van er N	. 1	USA 4. Race - Ame	rices Indian	
0.9	by Funerai	11. Marital Status  1 □ Never Married 2 ☒ M  3 □ Widowed 4 □ Divor	Married Am	is Decedent ned Forces? ]Yes 2 25 es, Give ar or Dates:		11	Vas Decedent of H Yes, specify Cuba ☐ Yes 2☑ No	ispanic Origin? in, Mexican, Pu Specify:	(Specify Yes of Netro Rican, etc.)		Black, White		
alcal I	eted	15. Dece (Specify only his	dent's Education ghest grade comp	oleted)	16a.	Deced (Give	ent's Usual Occup- kind of work done of OO NOT use retired	ation during most of v	vorking	16b. Kin	nd of Business/	Industry	
than a	Completed	Elementary/Secondary (0-1		llege (1-4or	5+)	life. L	NOT use retired Homemake				Home		
ent, II	0	12 17. Father's Name (First, Midd	die, Last)					18. Mother's N	lame (First, Middle	e, Maiden S			
atic ev	To B	Bernard Bente						Lyc	lia E. Le	gg			
7 is marked of treumatic eve		19a. Informant's Name/Relati William Ray W					g Address (Street : Prequassa				Town, State, 2		
tem 2 other	0	20a. Method of Disposition	223011, 5	2 6 / 1100	20b. Place of	Dispos	sition (Name of	1	Data	-	cation - City or		
nt: H	1	1 XBurial 2 ☐ Cremati  3 4 ☐ Donation 5 ☐ Othe		I from State			ven Cemet	ery	າໄດ້ 6, 2006	Gl	en Buri	nie, MD	
Importe any inju once.		21. Signature of Funeral Services	rice Licensee	h		B 42	Name and Address PS GOV. R	ss of Facility SONS itchie	P.A. Se Hwy: Se	verna verna	Park I	Tuneral	Home 45
		23a. Part1. Enfer the disease shock, or heart failure.	e or complication: List only one caus	s that caused se on each li	ine.			-				Approximate Interval Better Onset and I	ween
ician		Immediate Cause (Final disease or condition resulting in death)	a	Ric	spira	toz	y Four	lune				Oliset and t	764(11
dical niner		, , , , , , , , , , , , , , , , , , , ,		Due to (or as	a consequence	of): O	y Four	Blow	d of	Tum	ET 514	,	
	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying			a consequence	of):		10	2.07				
transi	Examin	Cause (Disease or injury that initiated events resulting in death) Last	C	Qualita (ar as	pagu	101	sathy						
the burial-transit	dicai E			ode to (or as	Cou	m	adin	/					
0 05	Φ.	IC CENAL E.		10				- 03/	98°5	-			
je 2 should be detached for use as	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	1.C 4 <u>C</u>	Live birth	of pregnancy 2		Ectopic pregnancy Other (specify)			2	3d. Date of del Month	,	fear
a deta	by Ph	Part II. Other significant con	ditions contributi	ng to death b	out not resulting it	n the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco us	se contribute to	the cause of d	eath?
d bluc		Cerona	y_A	1, se	ry DI	56	ase		_ 10	Yes 2	]No 3∏Pr	obably 4 🗖	Inknown
a 2 sho	Completed	Conges	fine_	Hea	ry -	7a	elure		24a. Wa auto	opsy	prior to	topsy findings completion of c	available ause of
, page	Con	Benign	From	wal	Tus	ne	~		per 1□ Yes	formed? 20X No	death?	2□ No	
certificate irector, pag	o Be	25. Was case referred to me examiner?	dical Hospita	l: 1 Vinanti	oot 2 🗆 EB/O	testion	Oth	00	Death (Check only		COther (See	mark al	
After this funeral di	Tampatient 2EP/Outpatient 3EDOA 4E Nursin							28d. Describe			Jny)		
he fur	atio	1 Natural 5 Pe	irijury		Yes 2 □ No								
ad in by	Certification:		termined 28e		jury - At home, fa tc. <i>(Specify)</i>	arm, str	eet, factory, office			(Street and own, State)	i Number or Ru	iral Route Num	ber,
To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edical	29a. Certifier   Check only one)	ical Examiner: O	To the best n the basis o nd manner st	of examination an	e, death	estigation, in my o	ne, date and pla pinion, death o	ace, and due to the courred at the time	e cause(s) a e, date and	and manner as place, and due	stated. to the cause(s	)
To the	Ň	29b. Signature and title of ce	ntifler	10	100	21	29c. Licens	e number		29d. Date	signed (Mont	h, Day, Year)	
		Judy	H /504	MA	01864	1	- De	043	371	7/	1/06	,	
		30. Name and address of per	son who complete	ed cause 64	death (Item 23a)	(Туре.	Print) KUSY A	NAP	10(15 m	20 =	2/40	,	
Sta	te	31. Date filed (Month, Day, Y			rar's Signature		- 1, "/"		/	-cx -	,70/		
Sta Registr		30. Name and address of per AMC 31. Date filed (Month, Day, Y	2001	MEJ 32. Progist	DICAL	(Туре.	Print) Kley A	NAP	rocis, n	10.5	21401	/	

DHMH 17 Rev 1/2001

**ORIGINAL** 

			For	State of M	faryland / Dep			ental Hygie	ne <sub>2</sub> 006	23190
			Registrar	(004)	Ce	ertificate of		Reg. 2. Date of Death	No.	3. Time of Death
	Physicia	an	Decedent's Name (First, Middle	E.	Winebr	onnor			Day Year	S. Time or Death
	/Medic		Gordon  4a. Facility Name (If not institution				r Location of Death	2119 12	4c. County of Deat	h
	Examin	er	M 1	11 .1 1	ĺ	Cumb	perland		Allega	
	Funeral		5. Social Security Number		ige (In yrs. last birthda)	y) If Under 1 Year		B. Date of Birth		hplace (State or Foreign
	Director		212-38-5283	1 XM 2□ F	69 Yrs.	Months Days	Hours Min.	B. Date of Birth (Month, Day, Ye Feb 13,	f937	MD
	2		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location				10d. Inside City Limits
	anyla •ho	5		gany		nberland			4	1 ☑ Yes 2 ☐ No
	28a-f	Director	10e. Street and Number			10f. Zip Code		10g.	Citizen of What Co	untry?
	3a or		220 Somerville	Avenue Apt.	202	1 100	21502		USA	
	affer death with the Maryland or Items 23s or 28s-f show impartment to putition at	Funerai	11. Marital Status	12. Was Deceden Armed Forces		B. Was Decedent of H	lispanic Origin? (Spec an, Mexican, Puerto R	ify Yes or No-	14. Race - Ame Black, White	
	or its	E	1 Never Married 2 ☐ Marr	ied 1 Yes 2 If Yes, Give	ŽNo	1 ☐ Yes 2 No	Specify:	ican, etc.)		
9500-5121	d within 72 hours after piene. r then "neturel", or ite tre Medical Examina	d by	3 Widowed 4 Divorced	Year or Dates	:			1	Specify: wh	
<u>ה</u>	"net	lete	15. Decedent (Specify only highes	i's Education it grade completed)	(Gi	cedent's Usual Occup ve kind of work done . DO NOT use retired	during most of working	9 160	. Kind of Business/	Industry
	within 72 ene. then "ner the Medic	Completed	Elementary/Secondary (0-12)	College (1-4or	n/a		-,	n/	а	
0	T to T	0	17. Father's Name (First, Middle,	Last)	1		18. Mother's Name (	First, Middle, Maid	den Sumame)	
Baltimore, Maryland 2	should be nd Mentel marked c	To B	Emerson G.	Winebrenner	r		Catherin	e F. (Bish	op) Winel	orenner
ary	d 2 should the and Ment of the market treumatic e		19a. Informant's Name/Relations			iling Address <i>(Street</i> 4 Oldtown	and Number or Rural	Route Number, Ci	ty or Town, State, 2	Zip Code) ID 21502
Σ.	s 1 and 3 f Heelth Item 27 other tr		Victor Winebre	nner brot						
ore	r of H		20a. Method of Disposition 1 → Surial 2 → Cremation	3 Removal from State	cemetery, ci	position (Name of rematory or other place			Location - City or	
	permit. Pag Department Important: eny Injury c		4 Donation 5 Other (S			lemorial Park			Cumberlan	id MD
Ba	permit. Pag Department Important: I eny Injury o		21. Signature of Funeral Service	Licensee	11		li Funeral Hor		1 MD 0450	20
			23a. Part. Enter the disease, or	complications that cause	ed the death. Do not e		ginia Avenue:			Approximate
3			spock, or heart failure. List	only one cause on each	line.		0000			Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)		eatic Care	cinoma u	with live	, WETAS	10515	915
	Examiner									
		ne	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or a	is a consequence of):					
	scuted ind transi	Examine	Cause (Disease or injury that initiated events resulting in death) Last	С.						
20,	ate be executed hysicien and the burial-transit	E E	resulting in death) Last	Due to (or a	is a consequence of):					
8760	m ∈ =	dicai		d						
9 X	certif ding se a	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcom					23d. Date of del	iverv
Вох	ath	Ciar	in the past 12 months?	4 ☐ Pregnant	at time of death	B □Ectopic pregnanc; D □ Other (specify) _	<i>y</i>		Month	Day Year
0	at the de by the ( tached	hys	9 ☐ Unknown	9□ Unknown		- 111200		-		
S,	The law requires that the the law sequires that the seen signed by the page 2 should be detache	by P	Part II. Other significant condition	ns contributing to death	but not resulting in the	underlying cause giv	en in Part I.	23e. Did tobac		the cause of death?
ğ	w require been signatured by	D D	Mental 1	etarda-	tion	<del></del>		1 ☐ Yes	2 12 No 3 □ Pr	obably 4 Unknown
Vital Records,	law r las be	Completed						24a. Was an autopsy	24b. Were au	topsy findings available completion of cause of
		ပ်						performed	No 1 ☐ Yes	200 No
Z I	Physiclan: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0t 0t	26. Place of Death			
ō	Phys this ral dis	. To	1 Yes 2 No 27. Manger of Death	1 Lampai		ient 3L DOA	4   Nursing Hom	e 5 ☐ Residence 3d. Describe how i	e 6 ☐Other (Spe niury occurred	cify)
on	Attending Physician: r death. ector: After this certifici by the funeral director.	tlor	1 Natural 5 Pendin		Day Year) Injury	∕ Woi	rk? ∣Yes 2∐No			
Division of	or Attendated after death Director:	Hice	3 Suicide 6 Could 4 Homicide determ	nined 286. Place of I	njury - At home, farm,	street, factory, office	28	Bf. Location (Stree City or Town, S	t and Number or Ru	ural Route Number,
۵	s after s after al Dire ed in b	Certification:	Tomose -		etc. (Specify)		l l			
	Hospital 24 hours 2 Funeral stely filled	edicai	29a. Certifier 1 Certifyir (Check only 2 Medical	ng Physician: To the bes Examiner: On the basis	st of my knowledge, de	ath occurred at the til	me, date and place, ar	nd due to the caus	e(s) and manner as	stated.
	To the Hospital or Ai within 24 hours after of To the Funeral Direc completely filled in by	Medi	one) 29b. Signature and title of certifie	and manner		29c. Licens	<u> </u>		Date signed (Mont	```
	5 × 5 0		255. Signature and the or certifie	and	all-	2	CILLII	.5	¬ .	
			30. Name and address of person	who completed cause of	death (Item 23a) (Tun	e Print	וווידיטי		110-0	XOOG
	5		Beverly M.	di.		morial	Ave Com	herlan	d. MN:	2006
	Sta	ite	31. Date filed (Month, Day, Year)	32. <b>Fil</b> gis	strar's Signature	Angel :			<del>~ 1111</del> (	
	Regist	rar	JUL 2	1 2006	ELAR SE S	E TOP SA				

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death 1. Decedent's Name (First, Middle, Last) 2 Date of Death Year **Physician** JULY 200 6 /Medical Christopher Anderson 4c. County of Death Examiner 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death ARUNDEL BALTIMORE WASHINGTON MEDICAL CENTER ANNE GLEN NIE If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | July 19,1963 Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** 1 M 2 □ F Yrs Director 220-88-1283 43 Maryland Usual Residence of Decedent 10a State 10b. County 10c. City. Town or Location 10d. Inside City Limits Funeral Director Maryland Anne Arundel Pasadena 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code CHRISTO MER "naturel", or Iteme 23e U.S.A. 8140 Orchard Point Road 21122 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☐ No
If Yes, Give
Year or Dates: 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: 2 3 ☐ Widowed 4 ☐ Divorced White Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation permit. Pages 1 and 2 should be filed within 7. Deportment of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "na eny injury or other traumatic event, the Market 2006. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 5 + General Manager Electrical Company 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 0 C. Ε. C1vde Anderson Patricia Johnson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 92 Clubhouse Drive Ocean Pines Maryland 21811 Tanya C. Anderson (Wife) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Bayview Crematory 7/25/06 Baltimore, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility McCully-Polyniak Funeral Home, P.A. 3204 Mountain Road Pasadena, Maryland 21122 Collins 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Acuilo **Physician** /Medical Due to (or as a consequence of) Examiner METABOLIC Sequentiarly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine /gpue The law requires that the death certificate be executed JOHY LAMON Due to (or as a consequence of): physician Box 68760 Physician/Medical MROM30 CHID PNEA IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months 4☐Pregnant at time of death 5 Other (specify) P.O. 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, <u>ک</u> 1 Yes 2 No 3 Probably 4 Junknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an ete hes page 2 s autopsy performed 2 No or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

Hospital: 1 ☐ npatient 2 ☐ ER/Outpatient

28a. Date of Injury (Month, Day Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.

3 Time of Death

1 ☐ Yes 2 ☐ No

Approximate Interval Between Onset and Death

Day

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

42 Ham

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 | Homicide 29a, Certifier 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address decrease who completed cause of death (Item 23a) (Type, Print) WASHINGSON 31. Date filed (Month, Day, Year) 32. Registrar's Signature

3 DOA

28b. Time of

28c. Injury at Work?

1 Tes 2 No

Registrar DHMH 17 Rev 1/2001

10

State

2

Certification:

Medical

Alter thi funeral

I Director: A

within 24 hours e To the Funerel C completely filled To the Hospital

death.

efter

1 ☐ Yes 2 No

5 Pending investigation

6 ☐ Could not be

27. Manner of Death

2 Accident

3 ☐ Suicide

1 Natural

**ORIGINAL** 

		For Stata Ragistrar	State of Maryl		partment of H e <i>rtificate of L</i>			giene <sub>2</sub>	06	23192
		1. Decedent's Name (First, Middle, La	st)				2. Date of Dea Month	ith Day	Year	3. Time of Death
Physicia /Medic		Mildred Ar	nold				July		006	10:40#
Examin		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Town, or	Location of Death		4c. County	of Death	
		Northwest Hos	pital			11stown			əltin	
Funeral		5. Social Security Number 6. S	Sex 7. Age (In	yrs. last birthda	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	Year)	9. Birthpi Coun	lace (State or Foreign
Director	ļ	217-26-1964	1 M 207	77 Yrs.			10-12-	-1928		yland
pus *	}	Usual Residence of Decedent  10a. State 10b. County	100	: City, Town or	Location				1	0d. Inside City Limits
laryla	5									1 □ Yes 2 No
Ne M	Director	MD Balti  10e. Street and Number	more	Reiste	rstown 10f. Zip Code			10g. Citizen of V	Mach Court	
with t	吉		1			2.0				uy:
72 hours after death with the Maryland natural', or Items 23e or 28e-f show dical Examinat must be notified at	Funeral	47 Shetland C	12. Was Decedent Ever	in II S	211.		oifu Vac or No	US/	ł. e - Americ	an Indian
ltem Item	Š	11. Marital Status  1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 🕅 No	11 0.3.	<ol><li>Was Decedent of Hi If Yes, specify Cuba</li></ol>	in, Mexican, Puerto	Rican, etc.)	Blac	k, White,	
irs aff	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 No	Specify:		Specify	cau	casian
2 hou	e	15. Decedent's E	ducation	16a. De	cedent's Usual Occupa	ation		16b. Kind of Bu	usiness/Inc	dustry
- 68	Completed	(Specify only highest gri	ade completed) College (1-4or 5+)	(Gi	ve kind of work done o . DO NOT use retired	during most of worki l)	ng	Bank	of i	America
filed within Hygiene. Ither than "	E	Elementary/Secondary (0-12)	4 (1-4015+)	С	PA					
be filec ital Hyg id othe event,	Bec	17. Father's Name (First, Middle, Last	unk			18. Mother's Name	(First, Middle,	Maiden Sumam	ie) []]	nk
id be lental ked o ic eve	ToB									
d 2 should be filed within the and Mental Hygiene. 7 is marked other than traumatic event, the Mental traumatic event.		19a. Informant's Name/Relationship (	Type, Print)	19b. Ma	iling Address (Street a	and Number or Rura	I Route Numbe	r, City or Town,	State, Zip	Code)
nd 2 alth a 27 is r tra		Dr. J. Anthony	Murray	or 651	1 Tydine	s Rd F	lderst	ourg. N	1D 2	1784
s 1 a		Edd. Highligh of Englishmen		Db. Place of Dis	position (Name of rematory or other place	, ,	ate	20c. Location -	City or To	wn, State
Page ento ento y or		1 ☐ Burial 2 ☐ Cremation 3 ☐ '4 ☐ Donation 5 ☐ Other (Special Control of the C			od Cem.	7/27/	'06 E	Parkvil	lle,	MD
permit. Pages 1 and 2 Department of Health a Importent: if item 27 is any injury or other tra		21. Signature of Funeral Service Lice		·	22. Name and Address					
Deg Tag		month	Mode							MD 21133
		282 Part1. Enter the disease, or com	mications hat caused the	death. Do not e	enter the mode of dyin	g, such as cardiac c	r respiratory ari	rest,		Approximate
Dhamisisa		shock, or heart failure. List only Immediate Cause (Final	one cause on each line.	Sm	all Cel	1cara	Inom	70- W	45	Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	a. Due to (or as a cor		1	, , , ,				
Examiner			CP Sel	6 - 6	11culo	1 cardia	Pef	Usias	2	
	ē	Sequentially list conditions, if any, leading to immediate	b. Due to (or as a cor	sequence of):	060		1			
uted	min	cause. Enter Underlying Cause (Disease or injury that initiated events	1//20	· ol	ettus	1 ons	•			
exec n an	Examiner	resulting in death) Last	Due to (or as a cor	nsequence of):						
cate be executed physician and sthe burial-transit	edical	(	d							
eath certific attending p	Physician/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pro		3 (75 stania			23d. Dat	e of delive	ry
death death d for	cla	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐Pregnant at time		3 □Ect <i>o</i> pic pregnancy 5 □ Other <i>(specify)</i>			Moi	nth	Day Year
the de by the attached	hys	9 🗆 Unknown	9□Unknown							
s that	by P	Part II. Other significant conditions	contributing to death but no	t resulting in the	underlying cause give	en in Part I.	23e. Did to	bacco use conti	ribute to th	ne cause of death?
quires n sign uld be							1 🗆 Y	es 2000	3 🗌 Prob	ably 4 □Unknown
w require s been si should b	Completed						24a. Was a	an 24b. V	Nere auto	psy findings available
he lav e has age 2	mc						autop: perfor	med?	death?	npletion of cause of
sician: The certificate h	Ö	25. Was case referred to medical				26. Place of Death			Yes	21.5410
ysicia is cert direct	OB	examiner? 1 ☐ Yes 2 ☐ MO	Hospital:	2 ER/Outpat	ient 3 DOA Othe				er (Specifi	()
Phy Phy G	-	27. Manner of Death	28a. Date of Injury	28b. Time	of 28c Injury			ow injury occurr		,
oding P th. : After e funera	ertification;	1 Natural 5 Pending 2 Accident investigation	(Month, Day Yea	ar) Injun		Yes 2 □ No				
Atter dea	fice	3 Suicide 6 Could not b	286. Place of injury -	At home, farm,	street, factory, office	:		treet and Numb	er or Rura	l Route Number,
d in t	ert	4  Homicide	building, etc. (S)	оеспу)			City or Tow	n, State)		
To the Hospital or Attending Physician: The law requires that the death certify thin 24 hours after death.  Within 24 hours after death.  We the Furnated Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	calC		hysician: To the best of my miner: On the basis of exa							
the H thin 24 the F mplete	Medical	one)  29b. Signature and title of certifier	and manner stated.		29c. License			29d. Date signed		
L S		Solvendo	Cennear	m.	0 0	1917	/_ (	アー/メ	19,	2006
( )		30. Name and address of person who	completed cause of death	(Item 23a) (Tvr	pe, Print)		ni	HOSVI	1/5	May well
U		Tolwards	eunan	40000	oe, Print)  I of Count	Road	///	, , , ,	21	205
Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's S	Signature	ef .					
Registr		111 2 5 2006	Bear 1	y Gos	all I					

		Decedent's Name (First, M.	liddle, Last)	)							2. Date of D Month	eath Day	Year	3. Time of De
Physici				K	lara Lo	uise A	rring	ton			July	20,		4:45 F
/Medio Examin		4a. Facility Name (If not instit	ution, give :	street and nu	mber)		4b. City,	Town, or	Location of	f Death		4c.	County of Dea	ith
		Esther's Plac	ce Ass	sisted	Living				timor		ty		N/A	
uneral		5. Social Security Number	6. Sea	к ]м 2.Пж.F	7. Age (In yrs		If Under Months	r 1 Year Days	If Under	24 Hrs. Min.	8. Date of B (Month, D	irth ay, Year)	9. Bir C	rthplace (State or F ountry)
rector		214-38-8566		7 ter = C-3/2	97	Yrs.					Feb.	21,19	09 Ge	rmany
¥		Usual Residence of Decedent 10a. State 10b. Co.			10c. C	ity, Town or L	ocation							10d. Inside City
d a	0	Maryland	N/A					B:	altim	ore	City			1 ☐ Yes 2
288	rec	10e. Street and Number	N/A				10f. Zip		OL 01.	020	0101	10g. Citi	zen of What C	ountry?
3a or	0	5008 Delagra	ange A	Ave.						2120	5	Uni	ted St	ates
od other than "natural", or items 23a or 28a-f show event, the Medical Exactinar must be notified at	Funeral Director	11. Marital Status		12. Was Dec	edent Ever in t	J.S. 13.	Was Dece	dent of Hi	ispanic Ori	gin? (Spe	cify Yes or N Rican, etc.)	10-	14. Race - Am	
29	Ē	1 Never Married 2	Married	Armed Fe 1 ☐ Yes If Yes, Gi	3/TNo				Specify:	i, Fuerto i	nican, etc.)		Black, White, etc.	
2 2	1 by	3 ∰Widowed 4 □ Divo	rced	Year or E	ates:		1 🗀 1 🙃	2(2) 140	эрвспу.					White
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E 2	mpi	Elementary/Secondary (0-	12)	College (	1-4or 5+)		DO NOT u			1-030		NI	v. zanana	× Co
문화		Ukn.	Idla I and			Ass	embly	Lin			(First, Middl		ewspape	r co.
Is marked other than aumatic event, It a M	Be	17. Father's Name (First, Mic							TO. MOUTE				e Langn	er
Item 27 is marked o other traumatic eve	2	Heinrick Ta		one (Print)		10h 14a:ii	in a Address	- /Ctt-	and Alumba			aber, City or Town, State, Zip Code) 212		
7 Is n		Beverly Erd		,pe, Print) (Guard	ian)		_			chmore Ave. Baltimore, Maryland				
om 27 ther tr				(								,	cation - City or	
		1 ⊠Burial 2 ☐ Cremat	1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State Cemetery, crematory or other place)											
Important: If Is eny injury or o once.		1111	or (Specify)	1-1	Par	kwood				-	/2006	В	altimor	e, Maryl
mpoi eny ir		21. Signature of Funeral Ser	TO TO	K	.////		2. Name ar )uda <b>-</b> F				ome of	Dune	dalk, I	inc.
2 0 U		1		1 0	00								and 2	
sician edical miner		shock, or heart failure. Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions,	List only of	Cause on	each line.  MC  (or as a conse	quence of):	ter the mod	de of dying	g, such as PCP	erdiac o	r respiratory	arrest,	Dou	Approximate Interval Betwe Onset and De
edical miner	ai Examiner	Immediate Cause (Final disease or condition	e, or compi	b.	each line.	equence of):	two	e uj	g, such as PCP	erdiac o	r respiratory	arrest,	Jou	Approximate Interval Betwe Onset and De
ed im provided and control or use as the purial-transit	icai	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that influence events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnan in the past 12 months?	List only of	De la ue to	(or as a conse	quence of):  quence of):  quence of):  quence of):	ter the mod	e uj	g, such as the p dis	erdiac o	r respiratory	Dru	Dou	Approximate Interval Betwee Onset and De
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			1 - For State Registrar	State of Ma	ryland / Depa <i>Ce</i>	artment o rtificate				gienę́ Reg. No.	2006	23194
È		u .	1. Decedent's Name (First, Middle, L.	ast)					2. Date of Dea	ath Day	Year	3. Time of Death
	Physici /Medic			Edith Alb	erta Amed	ore			July 1	-	2006	7:20 P M
	Examir		4a. Facility Name (If not institution, gi	ve street and number)		4b. City, Tow	n, or Location	n of Death		4c.	County of Dea	th
			8211 Shore Road			_	undalk				Balt	imore Co.
	Funeral Director			Sex 7. Age 1	(In yrs. last birthday) Yrs.	If Under 1 Y Months Da	ear If Unde ays Hours	Min.	8. Date of Birt (Month, Day May 22,	y, Year)		thplace (State or Foreign buntry) ryland
	p ,		Usual Residence of Decedent		10c. City, Town or Lo							
	aryla	_	10a. State 10b. County		Toc. City, Town or Lo	ocation		Dunda.	11-			10d. Inside City Limits 1 ☐ Yes 2000No
	Ba-f	Director	2	timore				Dunda.				
	ith th	E E	10e. Street and Number			10f. Zip Co	өb			10g. Citiz	zen of What Co	ountry?
	ath v	Funeral	8211 Shore Ro	<del></del>				222			ted St	
	tems	une	11. Marital Status	12. Was Decedent E		Was Decedent If Yes, specify (	of Hispanic O Cuban, Mexica	)rigin? (Spe an, Puerto F	cify Yes or No- Rican, etc.)	.   1	<ol> <li>Race - Ame Black, Whit</li> </ol>	
36	or l	by F	1 Never Married 2 Married	1 ☐ Yes 2 No		1 ☐ Yes 2 🛣	No Specify	y:			Specify:	
8	72 hours after death with the Maryland natural; or tems 23e or 28e-f show dical Examinat must be motified at	D D	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:	160 8	44-1110		-		101 101		White
21215-0036	- X 33	Completed	(Specify only highest g		(Give	dent's Usual O kind of work di DO NOT use re	one durina mo	ost of workin	g	100. Kir	nd of Business	Industry
12	within ene. then "	ᇤ	Elementary/Secondary (0-12) 12 Years	College (1-4or 5+	·)		,	_		TРа	warn/O	wn Home
	를 수 를 된		17. Father's Name (First, Middle, Las	t)	Ta	vern Ow	ner/Ho	memak her's Name	er (First, Middle,			WII HOME
Maryland	b d a b	o Be		,					abeth I			
2	should ind Men s marke umatic	5	Oscar Gatton  19a. Informant's Name/Relationship	(Type, Print)	19b. Maili	na Address (St	reet and Numb				Town, State, 2	Zin Code)
Ma	nd 2 shoulth and 27 is m		Mr. Mark Amedo		1	9 Todd				-	Point,	
	<u>a</u> <u>a</u> <u>a</u> <u>a</u>		20a. Method of Disposition	(5511)	20b. Place of Dispo	sition (Name o	of		ate		cation - City or	
<u>ē</u>	ages int of t::#iii		XXBurial 2 ☐ Cremation 3 I 4 ☐ Donation 5 ☐ Other (Spec		cemetery, crei		1	7 <i>/</i>	22/200			
Baltimore,	artme orten injury		21. Signature of Funeral Service Lice		Most Hol	y Redee 2. Name and A			22/2006	) <u> </u>	Baltimo	re, Maryland
Ba	permit. Pages 'Department of H Importent: If ite any injury or ot once.		Aregon &	: Kent	D 79	uda-Ruc 22 Wis	ck Fune e Ave.	ral H Dunc	lalk, M	arv1	dalk, I and 21	nc. 222
			23a. Part 1. Enter the disease, or con shock, or hear failure. List only	nplications that caused t v one cause on each line	he death. Do not ent	er the mode of	dying, such a	s cardiac or	respiratory ar	rest,		Approximate Interval Between
<b>V</b>	Physician		Immediate Cause (Final disease or condition	· SMALL	Cell WI	y Car	Nen					Onset and Death
ALC:	/Medical		resulting in death)	Due to (or as a	consequence of):	1						
18	Examiner		Sequentially list conditions,	b								
	D #	Inel	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Dua to (or as a	consequence of).							
79.	and and trans	Examine	that initiated events resulting in death) Last	C								
68760,	icate be executed physicien and s the burial-transit			Due to (or as a	consequence of):							
87(	ate b	dicai		d								
			IF FEMALE:	00- 16					_			
Вох	death certif e attending id for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 Live birth 2	Fetal death 3	Ectopic pregn				2	3d. Date of del Month	ivery Dav Year
0.	0 0 0	/sic	1 ☐ Yes 2 ☑ No 9 ☐ Unknown	4☐Pregnant at ti 9☐ Unknown	me of death 5	Other (specify	v)					24)
Θ.	that the de ed by the detached		Part II. Other significant conditions	contributing to death but	not reculting in the u	nderhing caus	anyon in Part		23e Did to	bacco us	a contribute to	the cause of death?
JS,	se un es	by	Tarris organization	continuating to double but	not resulting in the d	nuonying cause	given in ran					obably 4 Unknown
Records,	w requir been si should	Completed							101	03 2	3140 5 1	
lec	e law has b	nple							24a. Was a autop	sy	prior to	topsy findings available completion of cause of
H	T age	Co							perfor	med? 2 No	death?	2 No
of Vital	nding Physicien: Th th. : After this certificate s funeral director, pag	Be	25. Was case referred to medical examiner?	11				ce of Death	Check only or	10)		
of	this o	5	1 Yes 2 No	Hospital:							☐Other (Spec	cify)
n o	ing P	00	27. Manner of Death  Solution	28a. Date of Injury (Month, Day	Year) 28b. Time of Injury		Injury at Work?		8d. Describe h	ow injury	occurred	
Sic	Attending or death.	cat	2 Accident investigate 3 Suicide 6 Could not	00			1 Yes 2					
Division	il or Attend after death   Director: , d in by the f	Certification:	4 Homicide determined	28e. Place of Injur building, etc.	y - At home, farm, str <i>(Specify)</i>	eet, factory, off	ice	2	8f. Location (S City or Tow		l Number or Ru	iral Route Number,
	urs a											
	To the Hospital or Attant within 24 hours after deati To the Funeral Director: completely filled in by the	edical	29a. Certifier 1 Certifying P (Check only one) 2 Medical Exa	hysician: To the best of miner: On the basis of e	examination and/or in	n occurred at th vestigation, in r	ne time, date a my opinion, de	and place, a eath occurre	nd due to the o d at the time, o	ause(s) a date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Med	29b. Signature and title of certifier	and manner state	90.	29c Lic	cense number	<del></del>		Od Date	signed (Monti	Day Voorl
	To Too			00 00	20.							
			I will under	VIXII !	Hypicien	101	474		-	1/19	108	
	3		30. Name and address of person who	completed cau e of ea	at (Item 23a) (Type,	Print) カーゴルか	an A	V- 1	907	1180 4	0	114
			31. Date filed (Month, Day Year)	32 Registrar	's Signature	- 12N/16	14 /	1,000	MININ	VFP 1	ver L/	
	Sta Registr	ar	30. Name and address of person who MLYJR PUM.  31. Date filed (Month, Day, Year)	106	M. No	West !						

			1 State	State of Ma	arylan	d / Depa	artment <i>rtificate</i>	of He	ealth and	Mental Hy		the test that the	5 23 19
	*		Registrar     Decedent's Name (First, Middle, Last	<i>t</i> )		001	incate	OI L	, eath	2. Date of D			3. Time of Death
	Physici /Medio		Aaron, Boud	JR						Month	ر ص	ay Year	7:15 PM
1	Examir		4a. Fecility Name (If not institution, give	street and number)			4b. City, T	own, or l	Location of Deat	h		c. County of Dea	
			Baltimore VK			enter		Ba	Himan	- R_		N	A
п	Funeral		5. Social Security Number 6. S	7. Age Min 2□F		last birthday) Yrs.	If Under 1 Months	Year Days	If Under 24 Hrs Hours Min.	(Month, D	ay, Yea.	r) C	thplace (State or Foreign ountry)
_	Director		220-20-4960 Usual Residence of Decedent		76	113.				09/02/	192	9 Sout	h Carolina
	ylanc		10a. State 10b. County		10c. City	y, Town or Lo	cation						10d. Inside City Limits
	B Mau	ctor	Maryland			В	altimo	ore					1 DXYes 2 □ No
	ith th	Director	10e. Street and Number				10f. Zip 0	ode			10g. C	itizen of What C	ountry?
	s 23e		3741 Columbus Dr						215			.S.A.	
	Item Item	Funerai	11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent 8 Armed Forces?		S. 13.	Was Decede If Yes, specif	nt of His y Cuban	panic Origin? (S , Mexican, Puer	pecify Yes or N to Rican, etc.)	0-	14. Race - Am Black, Whi	
920	urs af	þ	3 Widowed 4 □ Divorced	1 Yes 2 □ N If Yes, Give Year or Dates:	№ 19. 19.		1 ☐ Yes 2	M⁄o√X	Specify:			Specify: B]	ack
Maryland 21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or items 23e or 28e-f show f.e Medical Execution mast be notified at	Completed	15. Decedent's Ed (Specify only highest gra	ucation		160 Dane	dent's Usual	Occupat	tion	tina	16b.	Kind of Business	/Industry
2	ithin	npie	Elementary/Secondary (0-12)	College (1-4or 5	+)	life.	DO NOT use	retired)	uring most of wo	Killy			
2	filed w Hygier other th		11 17. Father's Name (First, Middle, Last)			Shipp	ing Fo			/ /	-		lanufactor
auc	od of	Be c	Aaron Boyd Sr.							ne (First, Middle		n Sumame)	
<u> </u>	2 should be and Mental is marked (	ပ္	19a. Informant's Name/Relationship (7	voe Print)		19h Mailir	ng Address /	1		Johnson Johnson		or Town, State,	Zin Codol
<u>8</u>	D = 7 = 0		Authuretta Brodie	4									
<u>o</u>	s 1 ag f Hea item othe		20a. Method of Disposition		20b. P	lace of Dispo	sition (Name	of	oue, Bai	Date 28/2006	20c. l	ryland Location - City or	Town, Slate
Ë	Page nent o nt: if		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donetion 5 ☐ Other (Specify			rison				- •			s, Maryland
Baltimore,	permit. Pages 1 an Department of Heal Important: If item 2 any injury or other once.		21. Signature of Funeral Service Licen	•		22	. Name and	Address	of FacilityThe	Derric	k C	. Jones	F/H, P.A.
m —	882.58		We will		-								land 21215
			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	olications that caused one cause on each lin	the death	n. Do not ent	er the mode	of dying,	such as cardiad	or respiratory a	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a Seps	15								Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a		uence of):							100093
		_	Sequentially list conditions, if any, leading to immediate	b Due to (or as a	CONSECU	lence of):							
T	uted Insit	min	Cause (Disease or injury	0.00 (0. 0.00	2 00110000	301100 01).							
, ,	be executed sicien and burial-transit	Examiner	that initiated events resulting in death) Last	C. Due to (or as a	a consequ	ence of):							
68760	The law requires that the death certificate be executed tie hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	edical		d									
-	ng ph	Med	IF FEMALE:										
Box	eath certifi attending I for use as	Physician/M	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of 1 ☐ Live birth	2 🗌 Fetal	death 3	Ectopic preg				4	23d. Date of de Month	livery Day Year
o.	at the de by the a tached f	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4∏Pregnant at t 9☐ Unknown	time of de	eath 5	Other (spec	:rfy)				WOTH	Day 1 bai
<u>a</u>	res that the signed by be detaction		Part II. Dther significant conditions co	entribuling to death bu	it not resu	ulting in the ur	nderlying cau	se given	in Part I.	23e, Did	lobacco	use contribute to	the cause of death?
gg	uires sign lid be	d by					, ,	,			Yes 2	/	robably 4 Unknown
င္ပ	w requir	lete								24a. Was	an	24h Were a	stoney findings available
£	The law	Completed								auto	psy ormed/	death?	utopsy findings available completion of cause of
Vital Records,		BeC	25. Was case referred to medical					:	26. Place of Dea	1 ☐ Yes	2∭ No	o 1 ☐ Yes	2∰No
	Physic this ce al direc	10	examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 [ Inpatier	nt 2 🗆 E	ER/Outpatien	t 3□ DOA	Other			7.5	6 ☐Other (Spe	cify)
Ē	ding Ph h. After th funeral		27. Manner of Death 1 Natural 5 ☐ Pending	28a. Date of Injun (Month, Day	28b. Time of Injury		. Injury a Work?	at	28d. Describe	how inju	ry occurred		
<u>s</u>	tendi Jeath tor: A	cati	2 Accident investigation 3 Suicide 6 Could not be		М		es 2□No						
Division of	of or Attend efter death Director: d in by the f	Certification:	4 Homicide determined	28e. Place of Inju building, etc.	ry - Al hoi . (Specify	me, farm, stre	et, factory, o	office		28f. Location ( City or To	Street a wn, Stat	nd Number or Ri e)	ural Route Number,
	urs urs	C	29a. Certifier 1 Certifying Phy	sician: To the best o	f my knov	wledge, death	occurred at	the time	date and place	and due to the	Called/e	and manner of	stated
	P Hon	edicai	(Check only 2 Medical Exam	iner: On the basis of and manner stat	examinati	ion and/or inv	estigation, in	my opir	nion, death occu	rred at the time,	date an	d place, and due	to the cause(s)
	To the Hosy within 24 ho To the Fund completely f	Me	29b. Signature and title of certifier 29c. License number 29d. Date signed (Mod								ate signed (Mont	h, Day, Year)	
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	541		30. Name and ddr ss of person who d	ompleted cause of de	ath (Item	23а) (Туре, І	Print)				===	13310	
			31. Date filed (Month, Day, Year)	0 N. Gre	do Simo	Stre	et C	salt	more	MA	212	01	
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State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death MADELINE M. BURTON Year **Physician** 4.15 PM 2006 プレレソ /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner OSPITA Balhmo Ihmore Mer Cy Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Year If Under 24 Hrs. 8. Date of Birth (Month, Day, **Funeral** Days Min. Hours 1 M 2 F - 22 -Maryland Director Usual Residence of Decedent the Maryland 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-fahow f Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23a or 28a-f ahov other traumatic event, the Modical Examiner must be notified at 1 Yes 2 No N/A Baltimore Maryland Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with U.S.A. 21230 1544 South Hanover Street Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 Tyes 2 No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married White 1 ☐ Yes 2 No Maryland 21215-0036 Specify: 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) filed within Elementary/Secondary (0-12) College (1-4or 5+) Office Depot 0 Sales Assistant permit. Pages 1 and 2 should be file Department of Health and Mental Hy important; if Item 27 is marked other any injury or other traumatic. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Christine Unkown Robert Shipley Sr. 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21230 19a. Informant's Name/Relationship (Type, Print) 1544 South Hanover Street, Baltimore, Maryland George E. Burton Sr. (Husband) Baltimore. 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Crownsville VA Cem. 1 Ø Burial 2 ☐ Cremation 3 ☐ Removal from State 07-28-06 Crownsville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
4.5 cully-Polyriak Fungrel Home, P.A.
130 E. Fort Avenue, Ballimore, Maryland 21230 anna Approximate Interval Between Onset and Death Print. Enter the disease, or complicitions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, hock, or heart failure. List only one cause on each line. mediate Cause (Final Physician resulting in death) /Medical Due to (or as a consequence of) Examiner PANCROATIC CANCOT Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Completed by Physician/Medical Examiner ng physicien and as the burial-transit w requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) P.O. Box 68760, IF FEMALE: 980 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐Ectopic pregnancy for in the past 12 months? signed by the at id be detached for 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, 1 ☐ Yes 2 No 3 Probably 4 Unknown peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed page certificate PER 1 ☐ Yes 2 ☑ No MPIDEMIA 1 Yes 2/2 No Division of Vital Physician: ector, 25. Was case referred to medical examiner? Medical Certification: To Be 26. Place of Death | Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 3/1 No npatient 2 ER/Outpatient ₽ 1 Tyes 3 DOA this sid s after death.
I Director: After this id in by the funeral d 27. Manner of Death ate of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred or Attending 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No М 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di completely filled in Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number LEDATUS 047934 JULY, 24, 200 6 30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

1. I.E. DATUS MY 301 ST PAM. PL. BAYINONE , LEDATUS 31. Date filed (Month, Day, Year) State 2 5 2006 Registrar

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day 602 Physician PM JACK BOYD 07 06 23 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner JOHNS HOPKINS BAYVIEW BAUTIMORE If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) March 14, 1946 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1⊠M 2□ F 60 Yrs. Director 219-40-1939 Maryland Usuat Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show r than "natural", or Items 23a or 28a-f sho the Medical Examiner must be notified at 1 ☐ Yes 2 X No Director MD Baltimore Dundalk 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 210 Detroit Avenue USA by Funerai filed within 72 hours after death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No tf Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or Notif Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Mail Handler Fort Howard VA Hospital 12 years other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 2 shoutd be fi and Mental H Is marked of permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 is marked any injury or other traumatic evone. Rosalie Jackson Joseph Donald Boyd Sr. 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code, 19a. Informant's Name/Relationship (Type, Print) 7822 St. Fabian Lane, Dundalk, Maryland Teresa Marie Mc Carty Friend 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 31, Garrison Forest VA Cemetery 2006 Owings Mills, MD. 21. Signature of Funeral/Service Licenses <sup>22</sup> Name and Address of Facility Connelly Funeral Home Of Dundalk, P. A. 7110 Sollers Point Road, Dundalk, Md. 21222 23a. Part1. Enter the disease, or complications that caused the death to not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) Physician PNEUMONIA ASPIRATION 12 hours /Medical Due to (or as a consequence of): Examiner PANCREATIC CANCER 1 month Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner sician and A or Attending Physician: The law requires that the death certificate be executed physician and Due to (or as a consequence of) Box 68760, Physician/Medical for use as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Yes 1 ☐ Yes 2 No 2 No 25. Was case referred to medical examiner? 26. Place of Death (Check only one Other 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Inpatient 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA Sig. funeral 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred After s after decay alter al Director; Alter 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) filled in by 4 Homicide To the Hospital c within 24 hours aff To the Funeral Di 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai completely 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) RES-UOI 23/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JHBMC 4940 EASTERN AVE. JESSICA COLBURN, NO BALTIMORE, MD 21224 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. anend items 10a-ce, i per in 860 10-19-06 vt. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Dav Physician Month 11:40 AM July 15, 2006 Elizabeth Sarah Bane /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Kline Hospice House Mt. Airy Frederick If Under 1 Year | If Under 24 Hrs. | Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months 1 ☐ M 2 🖫 F 67 Director 219-34-8346 Oct. 24,1938 MDUsual Residence of Decedent Town or Location

Bentonville 10a. State 10c. City, 10d. Inside City Limits or than "naturel", or Iteme 23a or 28a-f ehow The Medical Examinar must be notified at Warren <u>Virgi</u>nia 1 ☐ Yes 2X No Directo Frederick 10e. Street and Number 462 Catron Ridge Road 10f. Zip Code 10g. Citizen of What Country? 22610 103 Orchard Drive 21788 USA within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify. þ Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry marked other than Elementary/Secondary (0-12) College (1-4or 5+) Homemaker 12 Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be . Pages 1 and 2 should be fill thent of Health and Mental H tant: if Item 27 is marked ott jury or other treumatic even Charles C. Stephens Etta Briggs 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Deborah B. Coe/Daughter 103 Orchard Drive, Thurmont, MD 21888 20b. Place of Disposition (Name of cometery, crematory or other place)
Shenandoan
Memorial Park 20a. Method of Disposition 20c. Location - City or Town, State permit. Page Department of Important: If eny injury or once. 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State 7-19-06 4 Donation 5 Other (Specify) Winchester, VA Turner-Robertshaw Funeral Home 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 1200 N. Shenandoah Avenue, Front Royal, VA 23a. Part Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) metastatic endometria **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine attending physician and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery signed by the atten Id be detached for u 3 Ectopic pregnancy Month Day 4☐Pregnant at time of death 5 Other (specify) o. 9 Unknown 9 Unknown ے 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 2 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy 1□ Yes 2 No 1 ☐ Yes 2 No Division of Vital tor: After this certific the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospice Hospital: 10 1 ☐ Yes 2 🖢 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA To the Hospital or Attending Pt within 24 hours after death.
To the Funeral Director: After the completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 5 Pending investigation 1 Natural Injury 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifig 29c. License number D0055061 July 2006

Registrar
DHMH 17 Rev 1/2001

State

300 West 9th Street, Frederick, MD 21701

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registrar's Signature

A. Nagy, MD

31. Date filed (Month, Day, Year)

2 5 2006

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OCY Space of Death (Check only one)  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1		BO)	ian/	in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy	
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29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29b. Signature and-titler of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)		The The page	So	performed? death?	
29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29b. Signature and-titler of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)		/ita	a)	examiner?	
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29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29b. Signature and-titler of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)		or At ther d tiract n by	III.	determined 206. Place of injury - At norme, farm, street, factory, office 28f. Location (Street and Number of Hural Houte Number	
Mp Kes 000 July 22 2006		Dital ours al			
Mp Kes 000 July 22 2006		Hosp 14 ho Fung Fung	ica	2 medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)	
Mp Kes 000 July 22 2006		the than 2 mplel	Med	and manner stated.	
A Name and address of person who committed cause of death (from 23a) (Type Print)		To Noil			
30. Name and address of person who commented cause of death (Item 23a) (Type Print)		<i>^</i>			
The state of the s		4		30. Name and address of petson who completed cause of death (Item 23a) (Type, Print)	
State 31. Date filed (Month, Day, Year) 38 Registrar's Signature				31 Date filed (Month Day Year) 38 Registrate Signature	
State State Registrar  111 2 5 2006  Since to sp. tul of Bolimore  Registrar  111 2 5 2006				111 2 5 2006 Robers De Aprile	

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Year ROWI 637PM Tuly 9 /Medical 2006 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death 4c. County of Death Examiner Hospital Baltimore Sinai NA If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral (Month, Day, Year) 06/13/1923 1 □ M 2 🕱 F Director Yrs 214-22-4024 Usual Residence of Decedent the Maryland 10a State 10h Counts 10c. City, Town or Location 10d. Inside City Limits Director 1 Yes 2 No baltimore spinas 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 27 ie marked othar than "natural", or items 23a or : traumatic event, the Modical Examinar must be r Gillingham 2111 by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 1 ☐ Yes 2 🗷 No If Yes, Give Year or Dates: 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 🗷 No 3 Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usuat Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) Coltege (1-4or 5+) Assembly Worker Grade NA Westinghouse 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental ! Sanders Seretha RHUR Murphy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) L. Gilliam 20b. Place of Disposition (Name of cemetery, crematory or other place)

Date

20c. Location - City or T. James 20a. Method of Disposition 20c. Location - City or Town, State permit. Pages 1 Department of H Important: If Ite any Injury or ot once. 1 Burial 2 Cremation 3 Removal from State 7/25/2006 Baltimore 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Functal SVC Youghn C. Greene Functal SVC 5151 Docto Natl Pite, Baltmore, MD 21229 21. Signature of Funeral Service Licenses vauchen Greene 23a. Part1. Enter the risk ase, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** Myocardial Infarct Acute disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of). Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) Physician/Medicai IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 □ Yes 2 ☑ No 23d. Date of delivery 3 Ectopic pregnancy Month 4☐Pregnant at time of death 5 Other (specify) certificate has been signed by the a rector, page 2 should be detached it 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ۾ Completed 3 ☐ Probably 4 ☐ Unknown 1 Tyes 2 □ No 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 100 1 Yes : After this certification, funeral director, Be 25. Was case referred to medical 26. Place of Death | Check only one Other: Certification: To 1 ☐ Yes 2 1 2 R/Outpatient 3 DOA 1 Inpatient 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred To the Hospitat or Attending within 24 hours after death.
To the Funeral Director: Alt 1 - Haturat 5 Pending investigation Injury 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Contifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) July 19, 2006 Thilli 00054482 30. Name and oddress of person who completed cause of death (Item 23a) (Type, Print) Patrick McLinkey West belveders Ave Baltimore, MU21215 m. 0 2401 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 25 2006 Registrar

velyn

Patient Known As

P.O.

Division of Vital Records,

Blanciak, Noi	Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Department of Health and Mental Hygiene. Important: If Item 27 ie markad other then "natural", or Items 23s or 28s
	Division of Vital Records, P.O. Box 68760,	of Attending Physician: The law requires that the death certificate be executed after death.  Director: After this certificate has been signed by the attending physicien and

		For State Registrar		State of M	aryland		irtment of <i>tificate of</i>	Health and <sup>f</sup> Death	Mental Hy	giene 2	006	2320
Physicia			e (First, Middle, Last) ea Blaucia	k	,,				2. Date of De		21006	3. Time of Death
/Medic Examin Funeral Director			If not institution, give so the Nashin Sew 220	aton Ma	1 17	enter st birthday) Yrs.	4b. City, Town, Glen If Under 1 Yea Months Days		s. 8. Date of Bin. (Month, Da	Ån.	ounty of Death  P. Birthp Cour  MD	umel place (State or Foreign
whow Let	7	10a. State	10b. County			Town or Loc					1	0d. Inside City Limits
3a or 28a-f at be notifie	Il Director	MD 10e. Street and Nu 216 Marg	Anne Ar mber ate Drive	undel	Gler	Burn	10f. Zip Code 21060	)		10g. Citizen	of What Cour	1 ☐ Yes 2 ☑ No
0 2	by Funeral	11. Marital Status	ied 2KMarried	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates:		lf	Vas Decedent of	Hispanic Origin? ( ban, Mexican, Pue	Specify Yes or No rto Rican, etc.)	14.	Race - Americ Black, White, ecify: whi	etc.
iene. Ithen "naturi Ite Medical E	Completed	(Spec	15. Decedent's Educity only highest grade andary (0-12)	cation completed) College (1-4or	5+)	(Give K life. D	ent's Usual Occu cind of work done O NOT use retire	e during most of w ed)	orking		of Business/Ind	dustry
Mental Hygi arkad other atic event,	To Be Co	17. Father's Name Joseph						18. Mother's Na	ume (First, Middle A. Hall	, Maiden Sur		
27 ie m 27 ie m or traum			ame/Relationship (Ty) ie1 J. Bla		oouse			tand Number or F Drive; G				Code)
nent of Heant If Item ury or othe		20a. Method of Dis			20b. Pla	ce of Dispos netery, crem	ition (Name of atory or other pla	ace)	Date 25-2006	20c. Locati	ion - City or To	
Departr imports any inju		21. Signature of Fu	ineral Service License	LIX r	1014		Name and Addr	ess of Facility S	ingleton	Funer	al Home	e, PA
iysician Medical xaminer		23a. Part1. Enter to shock, or head Immediate Cause disease or condition resulting in death)  Sequentially list co	on a	Due to (or as	est a	tic	the mode of dy	ing, such as cardia		rrest,		Approximate Interval Between Onset and Death
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en signed ould be del	۾	Part II. Other signif	icant conditions conf	ributing to death b	ut not resulti	ing in the und	derlying cause gr	ven in Part I.		obacco use c res 2 □ No		e cause of death? ably 4 Unknown
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ras after de rai Diracto lled in by t	ပ	3 Suicide 4 Homicide	6 Could not be determined	28e. Ptace of Injubulding, etc.	c. (Specify)				28f. Location (5 City or Tox	vn, State)		
in 24 hou	edical	29a. Certifier (Check only one)	1 Certifying Physi 2 Medical Examin	cian: To the best of er: On the basis of and manner sta	examination	edge, death on and/or inve	occurred at the ti estigation, in my	me, date and place opinion, death occ	e, and due to the ourred at the time,	cause(s) and date and plac	manner as sta ce, and due to	ited. the cause(s)
To	∑	29b. Signature and	enre (	E. W.	ile:	mnl	29c. Licent	Drive		July	21 j d	200 G
le		George	4	lis W	7.D	30) (Type, P	Yospita	l Drive,	Glen 1	Burn	re, MD	21061
Stat Registra		31. Date filed (Mon.	JUL 252	32. Registra	ar's Signatur	J. A.	parti					

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	Physic	an	1. Decedent's Name (First, Middle, La	st)						2. Date of De		-	3. Time of Death
	/Medi		Harriett M.	- V - W						07	22	2006	1530 M
4	Exami	ner	4a. Facility Name (If not institution, give		4 -		4b. City, Town, or		f Death		4c.	County of Dea	ith
			University of Manylan, 5. Social Security Number 6.5			ast birthday)	Baltin If Under 1 Year	I OVE	24 Hrc	0.0			
	Funeral Director			M 2⊠F 84	(III yrs. R	Yrs.	Months Days	Hours	Min.	8. Date of Bir (Month, Da 08-06	-192	1 0	thplace (State or Foreign ountry) A
	land w		10a. State 10b. County		10c. City	, Town or Lo	cation						10d. Inside City Limits
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	h the	Director	10e. Street and Number				10f. Zip Code			Ì	10g. Citi	zen of What C	ountry?
	th wi	aiD	15 Greenwood Ave	enue			21061				U.	S.A.	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Pygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny Injury or other traumatic event, it a Medical Exercities must be notified at appear.	by Funeral	11. Maritaf Status 1 □ Never Married 2 □ Married 3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:			Was Decedent of Hi f Yes, specify Cuba 1 ☐ Yes 25 No	spanic Orig n, Mexican, Specify:	in? (Spec Puerto R	ify Yes or No ican, etc.)	>-	14. Race - Am Black, Whi Specify: V	
2-0	72 ho	ted	15. Decedent's E (Specify only highest gra			16a. Deced	dent's Usual Occupa	ation	-1 -1:-		16b. Ki	nd of Business	/Industry
2	ithin	Completed	Elementary/Secondary (0-12)	College (1-4or 5+	-)	life. L	kind of work done of OO NOT use retired	iuring most	of working	9			
2	led w lygier her th		8			Hom	emaker					Own Ho	ome
and	tal H	Be	17. Father's Name (First, Middle, Last, Frank Livingston							First, Middle		Sumame)	
ž	hould d Mer mark matic	ဥ	19a. Informant's Name/Relationship (	Tues Count		40) 40 11				venson			· · · · · · · · · · · · · · · · · · ·
Z	d 2 s th an th an trau		Mr. Charles Bower	** **			g Address (Street a						
ē,	Hear Hear tem		20a. Method of Disposition	5 / 5011	20b. Pla	ace of Dispo.	eenwood A		Da Da			cation - City or	
9	Pages ent of nt: If i		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specif				matory or other place Mem. Par		7_27_	-2006			
Baltimore,	ortar Injur		21. Signature of Emerar Service Licer	Lan			. Name and Addres				Fun	eral Ho	gton, PA
ä	Deg e		- hill Stal	M611	20		Second A						
	Pnysician	9 89	28a. Party. Enter the disease, or com shock, or heart failure. List only immediate Cause (Final disease or condition	plications that caused to one cause on each line	he death.	Do not ente	er the mode of dying	g, such as c	ardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	conseque	ence of):							
<i>y</i> .		edicai Examiner	Sequentiafly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a	conseque	ence of):							
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P.O. Box	The law requires that the death certificete be executed the has been signed by the ettending physicien and bage 2 should be detached for use as the burial-transit	Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. ff yes, outcome of 1 Live birth 2 4 Pregnant at til 9 Unknown	Fetal	death 3	Ectopic pregnancy Other (specify)				2	3d. Date of dei Month	ivery Day Year
	s that ned b e deta	by P	Part II. Other significant conditions of	ontributing to death but	not result	ting in the un	derlying cause give	n in Part I.		23e. Did to	obacco us	se contribute to	the cause of death?
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Ĕ	of the state of th	lon:	27. Manner of Death 1 ⊠Natural 5 ☐ Pending	28a. Date of Injury (Month, Day 1	Year) 2	8b. Time of fnjury	28c. Injury Work		-	d. Describe h	ow injury	occurred	
<u> </u>	death death stor: , the f	cat	2 Accident investigation 3 Suicide 6 Could not be					es 2 □No					
Division of	after d after d Dirscl	Certification:	4 Homicide determined	28e. Place of Injury building, etc.	(Specify)	ie, farm, stre	et, factory, office		281	City or Tou	itreet and n, State)	Number or Ru	ral Route Number,
_	To the Hospital or Attendi within 24 hours after death. To the Funerat Director: A completely filled in by the tr		29a. Certifier 1 🔀 Certifying Ph	ysician: To the best of	my knowl	ledge, death	occurred at the time	a date and	place and	d due to the	Pallen(a)	and manager : -	stated
	n 24 t	edicai	(Check only 2 Medical Examone)	iner: On the basis of e and manner state	xamınatıc	on and/or invi	estigation, in my opi	inion, death	occurred	at the time,	date and	place, and due	to the cause(s)
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			mMein 1	- MD			AUYITE	1435 A	1/100	79	07	122/2	306
	6		30. Name and address of person who	completed cause of dea			rint)					100100	
				naghan	22	Sout	h Greene	Str	eet	Ba	eto.	MD	21201
¥	Sta Registra		31. Date filed (Month, Day, Year)  JUL 2 5	32. Registrar'	s Signatu	di. A	barte						

06-05163 Robert Bartulis

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

			ficate of Death	-	3. No. 200	6 23203
Physician	n/	Decedent's Name (First, Middle,Last)	D 1'	2. Date of Death Month	Day Year	3. Time of Death 0225 hrs
Medical Examin		Robert  4a. Facility Name (if not institution, give street and number)	Bartulis  4b. City, Town, or Location of Death	July 18, 20	4c. County of Deat	
	ı	3703 Ridgecroft Road	Baltimore		N/A	
Funeral	╗	5. Social Security Number 6. Sex 7. Age (In yrs. last	birthday) If Under 1 Year If Under 24Hrs  Months Days Hours Min		(MM/DD/YYYY) 9. Bi Forei	an
Director		212-46-5584   1XM 2 F   58	Yrs Days Hours Will	April	10,1948	ountry) Maryland
á		Usual Residence of Decedent  10a. State 10b. County 10c. City, To	own or Location			10d. Inside City Limits
d how a		Maryland Baltimore	Dundalk			1 Yes 2 X No
Aaryland 28a-f show any <u>1 at once,</u>	Director	10e. Street and Number	10f. Zip Code	100	g. Citizen of What Cou	untry?
ith the Maryland 23a or 28a-f sho notified at once.		8225 North Boundary Road	21222		United Sta	ites
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.	Funeral	11. Marital Status 1 Never Married 2 Married Armed Forces?	<ol> <li>Was Decedent of Hispanic Origin? (Spill Yes, specify Cuban, Mexican, Puerto</li> </ol>		14. Race - Ame White, etc.	rican Indian, Black,
er dear		1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	1 Yes 2 X No specify:		Specify:	White
urs aft tural'	핡	or Dates:	6a. Decedent's Usual Occupation (Give kind of		16b. Kind of Business	/Industry
6 72 ho an "na cal Ex	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	during most of working life. DO NOT use ret	red)		
003 within jiene.	틹	12 Years 17. Father's Name (First, Middle, Last)	Electrician 18.Mother's Name	/First Middle M		ectric Co.
215-0036 be filed within 7 ntal Hygiene. rked other than	Be C			Transik		
212 ould both d Ment s mark		Rudolph Bartulis  19a Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or			e, Zıp Code)
MD nd 2 sho alth and m 27 is		Mrs. Amy Johnson (Daughter)	8225 North Boundary		undalk, Ma	ryland 21222
ore, s l an of Hea			ace of Disposition (Name of cemetery, ematory or other place)	Date	20c. Location - City o	r Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Specify Hi	11top Service Corp.	7/21/200	6 Towson	, Maryland
Ball permit Depar Impo		21. Si pat e of Funeral Service Licensee	22. Name and Address of Facility Duda-Ruck Funeral	Home of	Dundalk,	
Physician	-	23a. Part I. Enter the disease, or complications that caused the death. D	7922 Wise Ave. In o not enter the mode of dying, such as cardiac of	or respiratory arres	Maryland st, shock, or heart	21222 Approximate Interval
/Medical	-	failure. Listophy one cause on each line.  Immediate Cause (Final disease a. Chronic ethanoli.	sm .			Between Onset and Death
Examiner	- 1	or condition resulting in death) Due to (or as a consequence of):				
	ا <sub>ة</sub>	Sequentially list conditions, if any, leading to immediate  b.  Due to (or as a consequence of):				<del>                                     </del>
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760, icate be executed g physician and the burial - transit	Ř	IF FEMALE: 23b. Was decedent pregnant in the			23d. Date of delive	·
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Rec The ficate	ទូ		OO Disease of Death (Observe	1 <b>Y</b> Yes 2		es 2 No
irector	å	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 E	26.Place of Death (Check R/Outpatient 3 DOA Other Nursin		Residence 6 🗸 Othe	er Scene
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the rs after cleath  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detactly	٩ ¡	27. Manner of Death 28a. Date of Injury 28a. (Marth Day Year)	8b. Time of Injury 28c. Injury at Work?		ow injury occurred	
ion fendin cath or: A the fu	Certification:	1 X Natural 5 Pending 2 Accident Investigation	1 Yes 2 No			
ivisi I or At after d Direct	ij	3 Suicide 6 Could not be 28e. Place of Injury - At hom	ne, farm, street, factory, office building, etc.	28f. Location (St or Town, Sta		ural Route Number, City
Ospital hours: neral		4 Homicide determined (Specify)  29a Certifier 1 Certifier Physician To the heat of my knowledge				2
Division of Vital Records, To the Hospital or Attending Physician: The law requivitin 24 hours after death To the Funeral Director: After this certificate has been scompletely filled in by the funeral director, page 2 should	ledical	one) Certifying Physician: To the best of my knowledge one) 2 ✓ Medical Examiner: On the basis of examination and				
To T To I	Med	and manner stated  29b. Signature and title of certifier	29c. License number		29d. Date signed (M	onth, Day, Year)
		Lungh Bruthall MA	O.C.M.E.		July 18, 2006	
d		30. Name and the ss of person who completed cause of death (Item 2	3a)			
Ø	( 3	Pamela Southall, MD Assistant Medical Examine		21201		AP
Sta Regist	ate	31. Date filed (Month, Day, Year)  32. Redistrar's Signature	1. Could			
Regist		HI 39 (MID) STORES &	- Park			

			1 - For State Registrar	State of Maryland /		rtment of H rificate of I		Re	g. No.	23204
	Physici	an	Decedent's Name (First, Middle, Last)	a day				Date of Death     Month	Day Year	3. Time of Death
b	/Medic	al	MITTON	130964				7	19 06	
1	Examin	er	4a. Facility Name (If not institution, give s Baltimore VA)			4b. City, Town, or	Location of Dea		4c. County of Dea	ath
			5. Social Security Number 6. Sex	Medical Cent		If Under 1 Year	if Under 24 Hrs			45 1 - (0)
	Funeral Director		213-54-4697	M 2□ F 55		Months Days	Hours Min		Year) 950	rthplace (State or Foreign country) MD
			Usual Residence of Decedent					bept. 2	, 1 , 2 , 9	HD
	yland		10a. State 10b. County	10c. City, Tox	vn or Loca	ation				10d. Inside City Limits
	Mar-fa	to	MD Baltim	ore Dunda	11k					1 □ Yes 2 No
	17 th	Director	10e. Sfreef and Number			10f. Zip Code		10	g. Citizen of What C	ounfry?
	15 w	ai	7229 Martell Av	enue		21222		U	SA	
5-0036	within 72 hours after death with the Maryland ene. than "netural", or lterns 23s or 28s-f show the Medical Exeminer must be motified at	by Funeral	11. Marital Status 1 Never Married 2 Married 3 Widowed M Divorced	2. Was Decedent Ever in U.S. Armed Forces? ₩_Yes 2 DNo If Yes, Give Year or Dates1 9 7 1 - 7 3	4.0	as Decedent of Hi Yes, specify Cuba ☑ Yes 2 🛣 No	spanic Origin? ( n, Mexican, Puel Specify:	Specify Yes or No- rto Rican, etc.)	14. Race - Am Black, Wh Specify:	
2-0	72 hg	Completed	15. Decedent's Educ (Specify only highest grade	ation 16a	. Deceder	nt's Usual Occupa	ation	orking 1	6b. Kind of Business	s/Industry
2	ithio	npi	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DC	O NOT use retired	)	-		
2	filed w Hygier Ather th	Co	10			Supervi			Printin	3
בַ	e d is b	Be	17. Father's Name (First, Middle, Last)	D = = 1 =				me (First, Middle, Mi	aiden Sumame)	
7/8	should be nd Menta marked umatic ev	٦	William Thomas				Doris			
Maryland 21	2 e e		19a. Informant's Name/Relationship (Typ William Bosley		b. Mailing	Address (Street a Martell	and Number or R Avenu	ural Route Number,		
	s 1 and 2 if Health Item 27 i		20a. Method of Disposition			tion (Name of	7	Dunda	1k, MD	
ס	00		1 XBurial 2 ☐ Cremation 3 ☐ Re	moval from State	ry, crema	itory or other place n Fores			oc. Location - City of Wings M:	
Itimore,	it. Partant	1	4 □ Donation 5 □ Other (Specify)  21. Signature of Funeral Service Licenses				- i -			
Ba	permit. Page Department Important: II any injury o		SHah	<del>\</del>	PA	2134	Willow	Spring	Road, 2	neral Home 1222
			23a. Part1. Enfer the disease, or complic shock, or heart failure. List only one	ations that caused the death. Do cause on each line.	not enter	the mode of dying	g, such as cardia	c or respiratory arres	t,	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	preumon	ia					Onset and Death
	/Medical Examiner		resulting in deafh)	Due to (or as a consequence						<i>il</i>
1	Examiner		Sequentially list conditions, if any, leading to immediate	non small ce	11 10	ung ca	ncer			4 months
	B 1/ 1/2	line	cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	OT):	J				
	and al-trar	Examin	that initiated events c. resulting in death) Last	Due to (or as a consequence	of):					
9	ificate be executed physicien and K		L.	.,						
98760	icate phys s the	edical	d.							
	eath certifi attending for use as		IF FEMALE: 23b. Was decedent pregnant	c. If yes, outcome of pregnancy					23d. Date of de	la
ň	death certi	Physician/M	in the past 12 months?	1 Live birth 2 Fetal death 4 Pregnant at time of death		ctopic pregnancy Other <i>(specify)</i>			Month Month	Day Year
J Ö	by the destached	hys	9 Unknown	9□ Unknown						
	law requires thet the es been signed by th 2 should be detache	by P	Part II. Other significant conditions conti	ributing to death buf not resulting	n fhe unde	erlying cause give	n in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Vital Records,	quire on sig uld b							1 ☐ Yes	2 □ No 3 🗷 P	robably 4 Unknown
ပ္တ	aw re s bee	Completed						24a. Was an	24b. Were a	ufopsy findings available
ř	0 - 6	E						autopsy	prior to death?	completion of cause of
g	ician: The certificete rector, pag	0	25. Was case referred to medical				26. Place of De	1 ☐ Yes 2	No 1 ☐ Yes	No
	Physician: r this certific ral director,	ToB	examiner? 1 ☐ Yes 2 No	spital: 1 Impatient 2 ER/O	utpatient	3□ DOA Othe	r	dome 5 ☐ Residen	ce 6 □Other (Sne	cifu)
	ding Ph After th funeral		27. Manner of Death	28a. Dafe of Injury 28b.	Time of	28c. Injury Work		28d. Describe how		ony)
Division		atic	1 Natural 5 Pending 2 Accident investigation	(World, Day Your)	ii i jut y		es 2 □ No			
<u>s</u>	er de	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Injury - At home, fabuilding, etc. (Specify)	arm, street	t, factory, office		28f. Location (Stre City or Town,	at and Number or R	ural Route Number,
בֿ	rs aft	Š		3, 10, 10, 10, 10, 10, 10, 10, 10, 10, 10				0.ty & . 0.th,	Sidile)	
	To the Hospital or Attan within 24 hours after deatl To the Funeral Director: completely filled in by the	edicai	29a. Certifier 1⊠ Certifying Physic (Check only one) 1⊠ Certifying Physic 2  Medical Examine	cian: To the best of my knowledger: On the basis of examination are and manner stated.	e, death o	occurred at the tim stigation, in my op	e, date and place inion, death occu	e, and due to the cau urred at the time, date	se(s) and manner as and place, and due	s stated. to the cause(s)
	Vithin On the	Me	29b. Signature and title of certifier	1,		29c. License	number	290	. Date signed (Mont	h, Day, Year)
	10		1/2-	hos MA		PI	9742		7/10	1/06
1	11,	-	30. Name and address of person who com	pleted cause of death (Item 23a)	(Type, Pri	int)	/			100
·			h . 1/	D MD 101	V Gr	eene St	Balti	more, A	1D 2120	71
	Sta		31. Date filed (Month, Day, Year)	32. Registrar's Signature	hosel	وع	<u>~</u>			
	Registr	-T2	DD Z 3 / UUU	TOTAL STATE OF STATE	200					

		1 - For State Registrar	State of Mai	-	artment of H			giene Reg. No.2	006	23205
Physici /Medi		1. Decedent's Name (First, Middle, Last)  Lois A. Baughm	an				2. Date of Dead Month July 1	ath 8, 200	06 Year	3. Time of Death 11:35P M
Examir		4a. Facility Name (If not institution, give s Suburban Hospi	tal		Bethese			Мо	unty of Death ontgome	
Funeral Director		5. Social Security Number 217-30-6122 6. Sex	7. Age	(In yrs. last birthday) 70 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Da August 2	year) 5, 1935	9. Birthp Cour Mar	place (State or Foreign http:// yland
Maryland I-f show	tor	10a. State 10b. County  Maryland Montgomery		10c. City, Town or Lo	cation				1	0d. Inside City Limits
h with the 23a or 28a at be noti	ai Director	10e. Street and Number 17431 Saint Ther	esa Drive		10f. Zip Code 20832				of What Cour	
5-UUSD 72 hours after death with the Maryland natural', or items 23a or 28a-1 show dissal Examiner must be notitied at	by Funeral	11. Marital Status  1 □ Never Married 2 ☒ Married  3 □ Widowed 4 □ Divorced	2. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 🛣 No If Yes, Give Year or Dates:	1	Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 🕅 No	ispanic Origin? (Sp an, Mexican, Puerto Specity:	ecify Yes or No Rican, etc.)		Race - Americ Black, White, ecity: Wh	
within then he	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 1.2	cation completed) College (1-4or 5+)	(Give	dent's Usual Occupi kind of work done of DO NOT use retired	during most of work d)	ing	Montg	of Business/Ind gomery ic Scho	County
be filed that Hyg ad othe	To Be C	17. Father's Name (First, Middle, Last)  Calvin Z. Koons				18. Mother's Nam	ller			
		Wesley Baughman/hu 20a. Method of Disposition	•	1743	ng Address (Street at 1 Saint 1 string)	Theresa D	rive, O	lney,		832
Dallimore, permit. Pages 1 ar Department of Hea Important: if item any injury or othe		1 ☐ Burial 2 ☐ Cremation 3 ☐ R. 4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Funeral Service License		Montgomery	Crematorium  Name and Address  ODETT A. Pi	n 20	06	Bethe	esda, M	aryland
		23a. Part1. Enter the disease, or compleshock, or heart failure. List only on	Jewy	)11/3 3	00 W. Mont	gomery Ave	nue, Rock	wille,	MD 20	Approximate Interval Between
Physician /Medical physician and Examiner and Examiner as the prival-transit	edicai Examiner	Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	consequence of):  consequence of):  consequence of):	enocarc	inoma Greas	+			S Wo
The Course, the contribution is a second of the contribution of th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	ic. If yes, outcome of 1 Live birth 2 4 Pregnant at tir 9 Unknown	Fetal death 3	Ectopic pregnancy	,		23d	. Date of delive	ery Day Year
w requires thet been signed b	Ď	Part II. Other significant conditions con	tributing to death but	not resulting in the u	nderlying cause give	en in Part I.	23e. Did to	-		ne cause of death?
	Completed	kidney fail	uve						prior to cor death?	psy findings available mpletion of cause of
Physician: The Physician: The This certificate ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		Othe	26. Place of Deat		-		
ding Phy h. After this funeral o	tion; To	27. Manner of Death	28a. Date of Injury (Month, Day)	28b. Time of	28c. Injun Work	4   Norsing no	ome 5 Resid			γ)
to:	Certification;	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc.	y - At home, larm, str (Specify)			28l. Location (S City or Tow	treet and N n, State)	umber or Rura	il Route Number,
To the Hospital or Al within 24 hours after or To the Funeral Direc completely filled in by	Medical C	29a. Certifier 1 Certifying Physical Check out 2 Medical Example 29b. Signature and title bilderitier	ician: To the best of er: On the basis of e and manner state	xamination and/or in	occurred at the time vestigation, in my operation of the control o	pinion, death occur	red at the time,	date and pla	d manner as stace, and due to	the cause(s)
A 2 2 2 8		30. Name and address of person who co	mpleted cause of dea	ath (Item 23a) (Type,	02	1531		July	19,2	006
Sta		G. Peter Pushkas, 31. Date filed (Month, Day, Year)	M.D. 115	10 01d_Ge		Road, Roo	ckville,	MD	20852	

7118106 2335

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Baughman, 6015

			1 - For State Registrar	State of	Marylar	•	artmen rtificat			and M		Reg. No.	006	23	206
	Physici		1. Decedent's Name (First, Middle, Las Marie Baldassa	•							July 1		006 Year	3. Time o	
	/Medio Examin		4a. Facility Name (If not institution, give		ber)		4b. City,		Location o			4c. C	ounty of Dea		
			319 Grandin Avenu		. Age (In yrs.	last hirthday)	If Under	Ro 1 Year	ckvil		8 Date of Bir		ontgom	ery thplace (State	or Foreign
	Funeral Director			□M 2X1F	86	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da March 2	, Year)	) $M_{1}^{C_0}$	nnesota	
	land w		Usual Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	ocation							10d. Inside (	City Limits
	a-f sh	ctor	Maryland Montgome	ery	Ro	ckvill	e							1∭Ye:	s 2 No
	with the	Director	10e. Street and Number				10f. Zip						en of What Co	-	
	ns 234	Funeral	319 Grandin Aven	12. Was Deced	lent Ever in U	.S. 13.1	Was Dece	0850 dent of Hi	spanic Orio	gin? (Spe	ecify Yes or No		ed Sta		
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If item 27 is marked other than "natural', or items 23s or 28s-1 show spirity or other treumatic event, the Madical Examination must be notified at ODGe.	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	Armed Ford 1 Tes 2 If Yes, Give Year or Dat	es? ∑∑No		If Yes, spe 1 ☐ Yes	cify Cubai	Specify:	i, Puèrto	Rican, etc.)		Black, Whit	o, etc. Vhite	
5-0	"natur	Completed	15. Decedent's Ed (Specify only highest gra			16a. Dece (Give	dent's Usu kind of wo DO NOT u	rk done a	lurina most	t of worki	ng	16b. Kind	of Business	/Industry	
212	d within	фшо	Elementary/Secondary (0-12)	College (1-	4or 5+)		Secre					Def	ense (	Contrac	tor
Maryland 21215-0036	uld be file Jental Hyg rked othe	To Be C	17. Father's Name (First, Middle, Last) Carl John Palm								(First, Middle Holen	, Maiden S	u <i>mame)</i>		
Man	12 sho h and h rie ma reuma		19a. Informant's Name/Relationship (		1	1	-				I Route Numb				20001
ē,	f Healt Hem 2:		Victoria Baldass 20a. Method of Disposition		20b. F	Place of Disponentery, creation	sition (Nai	me of		uly	Silver		ation - City or		20901
Ë	Page ment o ant: If ury or		1 N Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specification 5 □ Other (Specification)		เลเด	klawn M	-			2006	5	Rock	ville,	Mary1	and
Baltimore,	permit. Departimont. Import. eny inj		21. Signature of Funeral Service Lice	phy	M0117	73 RS	bert A	nd Addres Pump Montgo	s of Facilit hrey I mery	Y Funera Ave nu	al Home, ie, Rock	Rockv ville,	ille, I Maryla	nc nd 20850	
	Physician		23a. Part1. Enter the disease, or com- shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on ea	ch line.	th. Do not ent 7e Hear				cardiac c	or respiratory a	rrest,		Approxima Interval Be Onset and 1 yea	etween I Death
	/Medical Examiner		resulting in death)	α	r as a consec				-						
	pe sit	niner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (c	r as a eonsec	quenes of):							1		
8760,	icate be executed physician and s the burial-transit	al Examiner	that initiated events resulting in death) Last	c. Due to (o	r as a consec	quence of):									
9	ificate g phys as the	edic		_ d											
Box	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown		th 2 ☐ Feta nt at time of c	aldeath 3	]Ectopic p					23	d. Date of de Month	livery Day	Year
P.0.	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions of	ontributing to dea	ath but not res	sulting in the u	nderlying o	ause give	n in Part I.		23e. Did t	obacco use	a contribute t	the cause of	death?
rds	w requires that been signed to should be det	ed by	Hypertension, H	yperlipi	ldemia,	Diabe	tes				10	Yes 2∭	No 3∏P	robabiy 4 🗆	]Unknown
Reco	The law re ate has bee page 2 sho	Completed										psy prmed?	prior to death?	utopsy findings completion of	s available cause of
ita	lan: T	BeC	25. Was case referred to medical examiner?						26. Place	of Death	1 ☐ Yes 1 (Check only o	24 No	1 🗆 Yes	2 □ No	
of <	Physician: r this certificanal director.	၉	1 X Yes 2 □ No  27. Manner of Death	Hospital: 1 ☐ In 28a. Date of		ER/Outpatier			4 🗀 110		me 5K Resi			cify)	
O	Attending r death. ector: After by the funer	ation	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month	Day Year)	Injury	м	28c. Injury Work 1 🔲 Y	.? ∕es 2 🔲 I		28d. Describe	now injury	Scanea		
Division of Vital Records,	al or Atter s after dea il Director id in by the	Certification:	3 Suicide 6 Could not b 4 Homicide determined	280. Place 0	of Injury - At h g, etc. (Speci	ome, farm, str fy)	reet, factor	y, office			28f. Location ( City or To	Street and wn, State)	Number or Ri	ura <i>l R</i> oute Nur	mber,
	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	edicai C	29a. Certifier (Check only one)  1 Certifying Ph 2 Medical Exam	ysician: To the base niner: On the base and manner	sis of examina	owledge, deat ation and/or in	h occurred vestigation	at the tim	e, date an	d place, th occurr	and due to the ed at the time,	cause(s) a date and p	nd manner as lace, and due	s stated. to the cause(	(s)
	To the within 7 To the comple	Ž	29b. Signature and title of certifier	1 d.m	0			c. License					signed (Mont		
,	T		30. Name and address of person who	-/-		m 22c\ /T		D3183	) Y 			Jul	Ly 19,	2000	
1	0		Christopher C. D	-		615 W.	Mon	tgome	ery A	venu	e Roc	kvill	e, Mar	yland	20850
	Sta Registi		31. Date filed (Month, Day, Year)	06 32.7Re	gistrar's Sign	after A	self)								

			State of Maryland / De	epartment of Health Certificate of Death		ntal Hygiei	21116	23207
			Registrar  1. Decedent's Name (First, Middle, Last)	or models or boding		Date of Death		3. Time of Death
	Physicia		Donald Ervin Buglas	S	J	Month uly 19	Day Year 2006	4:15 A M
	/Medic Examin	100	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location	of Death		4c. County of Death	
В	Ø.,	- Ser	Potomac Valley Nursing and Wellness Center	Rockville			Montgome	ry
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birtho	Months Days Hours	Min. 8	Date of Birth (Month, Day, Ye	9. Birth	nplace (State or Foreign untry)
	Director		370-30-1124	š	J	uly 26,	1914   Wisc	consin
	and w		Usual Residence of Decedent           10a, State         10b, County         10c, City, Town or	r Location				10d. Inside City Limits
	Mary f ehc	jo	Maryland Montgomery Beth	nesda				1 ∐ Yes 2 🛣 No
	1 the	Director	10e. Street and Number	10f. Zip Code		10g.	Citizen of What Co	untry?
	h with		6913 Anchorage Drive	20817		U	nited Sta	tes
	filed within 72 hours after death with the Maryland Hygione. Hygiona Insturel; or Items 23a or 28e-f ehow sit, ira Madical Exardi at must for incilited at	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic On If Yes, specify Cuban, Mexica	rigin? (Specif	y Yes or No-	14. Race - Amer Black, White	
õ	or Ite		1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 🛣 No If Yes, Give	1 ☐ Yes 2 X No Specify		,		hite
ë	urel',	d by	3 X Widowed 4 □ Divorced Year or Dates:			100		
7	n 72 i	Completed	15. Decedent's Education (Specify only highest grade completed)	ecedent's Usual Occupation Give kind of work done during mot fe. DO NOT use retired)	st of working	160	. Kind of Business/I	naustry
7	withi ene. then	mc	Flementary/Secondary (0-12)   College (1-4or 5+)	ountant / Bookk			Federal G	overnment
D D	filed Hygi other ent, I	Be C	17. Father's Name (First, Middle, Last)	18. Moth	her's Name (F	First, Middle, Maid	den Sumame)	
a	should be filed within 72 hours after death with the Marylan of Mental Hygiens. The marked other than "naturel", or flems 23a or 28e-f ehow marked other than "naturel", or lems 23a or 28e-f ehow marked other than "naturel", or lems 12a or 12e-f ehow marke ovent, the Medical Exacult at marked ovent, the Medical Exacult at marked ovent, the Medical Exacult at marked over the marked of the marked over the marked o	To B	Peter Buglass	P	Martha	Davis		
ar	2 should and Men ie marke aumatic	-	19a. Informant's Name/Relationship (Type, Print) 19b. N	lailing Address (Street and Numb	ber or Rural F	Route Number, Ci	ty or Town, State, Z	ip Code)
Σ,	and 2 lealth a m 27 to her tra			2 Selworthy Roa	ad, Roc			
altimore, Maryland 21215-0036	of Figure 1		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State  20b. Place of D cometery,	isposition (Name of crematory or other place)	July 2	24.	. Location - City or	Town, State
Ĕ	Pages ment of ent: If It ury or o		4 □ Donation 5 □ Other (Specify)  Mauston C	city Cemetery	2006		uston, Wi	sconsin
Balt	permit. Pag Department Importent: I any injury o		21. Signature of Fuperal Service Licensee	22. Name and Address of Facil Robert A. Pumphrey	Funeral	. Home/Betl	nesda-Chevv	Chase, Inc.
	00 = 0	Ш		Robert A. Pumphrey 7557 Wisconsin Aver				4-3501 Approximate
		00	23a. Part / Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line.	1 · A	1	espiratory arrest,		Interval Between Onset and Death
St.	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	espiralory	160	alux	2	
1	Examiner		Due to (or as a consequence of)	0	P	0.		
E.		e.	Sequentially list conditions, if any, leading to immediate b. Due to (or as a consequence of)	Kene.	tou	Lure	*	
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events c.					
o Î	exec en and rial-tra	Еха	resulting in death) Last Due to (or as a consequence of)	:				
8760	cate be executed bhysicien and the burial-transit	dicai	<b>d</b>	· · · · · · · · · · · · · · · · · · ·				
Õ	ntifica ng ph a as th	Med	IF FEMALE:					
Вох	The faw requires that the death certific tte has been signed by the attending pi tage 2 should be detached for use as i	Physician/Me	23b. Was decedent pregnant  1 ☐ Live birth 2 ☐ Fetal death	3 Ectopic pregnancy			23d. Date of deli	very Day Year
o.	the all	sici	1 Yes 2 No 4 Pregnant at time of death 9 Unknown	5 Other (specify)		<del></del>		,
مـُ	res that the de signed by the a be detached f		Part II. Other significant conditions contributing to death but not resulting in the	ne underlying cause given in Part		23e. Did tobac	co use contribute lo	the cause of death?
ds,	signe d be	d by	Doute CANCER			1 ☐ Yes	2 <b>X</b> No 3 □ Pro	obably 4 Unknown
ŏ	w requir been si should	etec	THE CONTRACTOR			24a. Was an		toney findings available
e E	has ge 2	Completed		··		autopsy	death?	topsy findings available completion of cause of
ē	n: Th ficate or. pa		25. Was case reterred to medical	OC Dies	of Dooth //	1 ☐ Yes 2	No 1 ☐ Yes	2 No
5	s cert irect	To Be	examiner?  1  Yes 2 No  Hospital: 1  Inpatient 2  ER/Outp	Othor		Check only one)	e 6 □Other (Spec	ufu)
ō	g Phy er the		27. Manner of Death 28a. Date of Injury 28b. Tin	ne of 28c. Injury at		d. Describe how i		,,,
<u>0</u>	ath. r: Att	atlo	1 Natural 5 □ Pending (Month, Day Year) Inju 2 □ Accident investigation	M 1 Yes 2	□No			
Division of Vital Records,	r Atte	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury. At home, farm building, etc. (Specify)	n, street, factory, office	28	Location (Stree City or Town, S	t and Number or Ru tate)	ral Route Number,
٥	rs aft el Di ed in	Cer						
	To the Hospital or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	edical	29a. Certifier  (Check only  2 Medical Examiner: On the basis of examination and/	death occurred at the time, date a or investigation, in my opinion, de	and place, and eath occurred	d due to the caus at the time, date	e(s) and manner as and place, and due	stated. to the cause(s)
	thin 2 the mplet	Med	one) and manner stated.  29b. Signature and title of certifier	29c. License number	r	29d.	Date signed (Monti	n, Day, Year)
Y			LETESORYYDOW MO	Dooks	247		7/19/	700€
,	OF		30. Name and address of person who completed cause of death (Item 23a) (To	(De. Print)	-13-	~	1/1//	
	U		SAYEDM. ELSAYAAD 9	715 Nechila	Conte	Dr. Ko	ckville	MD 20850
R.	Sta	ite	31. Date filed (Month, Day, Year) 32. Registrar's Signature	29c. License number  10065  7/pe, Print)  7/5 Nech'(2)				
	Registi	rar	JUL 2 5 2006 Julius De a					!

			For State Registrar	State of Ma	ryland /		tment of Heificate of L			giene Reg. No.	006	23208
	-		Decedent's Name (First, Middle, Last)						2. Date of De. Month	ath Day	Year	3. Time of Death
	Physicia /Medic		Ruth S. Barne	ett					July	20, 2	006	1:20 A M
/.	Examin		4a. Facility Name (If not institution, give st	reet and number)			4b. City, Town, or	Location of Death			ounty of Deat	
			Shady Grove Advent				Rockvil				lontgom	
	Funeral		5. Social Security Number 6. Sex	a₩n =	(In yrs. last b		If Under 1 Year Months Days	Hours Min.	8. Date of Birt (Month, Da	v. Year)	Co	nplace (State or Foreign untry)
Ц.	Director	-	577-58-8382		63	Yrs.			June 25,	, 1943	Mar	yland
	and and	-	10a. State 10b. County		10c. City, To	wn or Loca	ation					10d. Inside City Limits
	Mary f sh	ğ	Maryland Washingto	in	Boone	esbor	0					1 ☐ Yes 2 No
	death with the Maryland me 23a or 28a-f show rmust be notified at	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Citize	n of What Co	untry?
3	3a o	2	19314 Manor Churc	ch Road			2171	.3		Unit	ed Sta	tes
	deat me	ner	11. Marital Status	2. Was Decedent E Armed Forces?	ver in U.S.	13. W	as Decedent of Hi	spanic Origin? (Sp	ecify Yes or No	- 14	Race - Ame Black, White	
Maryland 21215-0036	be filed within 72 hours after death with the Marylan Hygiene. Hygiene, the Hygiene do other than "naturel; or lieme 23a or 28a-f show event, the Madical Examiner must be notified at	þ	1 ☐ Never Married 2 ☐ Married 3 ☐ Widowed 4 🛣 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	D		□Yes 2 No	Specify:		s		White
ဥ	72 ho	Completed	15. Decedent's Educi (Specify only highest grade	ation completed)	16	a. Decede	ent's Usual Occupa	tion uring most of work	ing	16b. Kind	of Business/	Industry
7	within 72 ene. than "na the Medic	npie	Elementary/Secondary (0-12)	College (1-4or 5+	-) D	life. Di	O NOT use retired,	)		M t-		0
7	filed wi Hygien other th	Co	12		Ъ	eputy	Registe					County
	uld be fil fental H rked ott tic even	Be	17. Father's Name (First, Middle, Last)	0 - 1 1-				18. Mother's Nam				
$\frac{8}{5}$		T <sub>0</sub>	Alfred Winfield		10	Ob. Mailing	Address (Street a		Lorrain			Zin Code)
<u> </u>	2 E 2 E		19a. Informant's Name/Relationship (Type Kenneth W. Jones/s				Veirs M				ille,	
	1 and 1 and		20a. Method of Disposition		20b. Place	of Dispos	ition (Name of	1	Date	20c. Loca	ation - City or	Town, State
	Page nent c ant: If		1 X Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)		Pleasar	Garder	110-1	20	24 <b>,</b> 06		insbur t Virg	4.
Bail	permit. Depertr Imports any inju		21. Signature of Funeral Service License William A. Hill	uphren !	M01173	Rob 300	Name and Address ert A. Pur W. Montgo	phrey Fund mery Aveni	ral Home ie, Rockv	, Rock	ville, I Maryland	nc. 1 20850
			23a. Part1. Enter the disease, or complice shock, or heart failure. List only one	ations that caused cause on each line	the death. Do	o not ente	r the mode of dying	g, such as cardiac	or respiratory a	rrest,		Approximate Interval Between
, ı	Physician		Immediate Cause (Final disease or condition	500	hic		she					Onset and Death
١.	/Medical		resulting in death)	Due to (or as a	consequenc							
	Examiner		Sequentially list conditions, b.	620	m	1	1290	Fire	356	CIZ		
	<u>ت</u> و	iner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	i conséquenc	a ol).		0-				
	ecute and -trans	Examiner	that initiated events c.	Due to (or as a	CONSAGUANC	e of):	90	14161	no	V/d		
8760,	be ex icien burial	E		C3 ( )	\- <del>-</del>	× (	= 101	inter.	L ;	ail	12	
87	icate be executed physicien and s the burial-transit	dical	d.	- 3( )					7 -9			
9 X	eath certifi attending p I for use as	/Me	IF FEMALE: 23	3c. If yes, outcome of	of pregnancy					23	d. Date of del	iverv
ñ	eath atter I for u	ciar	23b. Was decedent pregnant in the past 12 months?	1 ☐Live birth 2 4 ☐ Pregnant at 1			Ectopic pregnancy Other (specify)				Month	Day Year
P.O. Box	uires that the de i signed by the a Id be detached f	Completed by Physician/M	1 ☐ Yes 2 ☑No 9 ☐ Unknown	9□ Unknown								
<b>o</b> .	s that	Y P	Part II. Other significant conditions con-	tributing to death bu	f nof resulting	g in the un	derlying cause give	en in Part I.	23e. Did f	obacco use	e contribute to	the cause of death?
S	n sign	g D	12101	4+35	S				10	Yes 2	<b>√</b> 0 3 □ Pr	obably 4 Unknown
8	sw requires s been si s should I	jet							24a. Was			fopsy findings available
8	The lav	E							auto perfo	psy ormed? 2 X No	death?	completion of cause of
ta	an: Tifica tor, p	BeC	25. Was case referred to medical					26. Place of Dea				
<u> </u>	ysici is cer direc	To B	examiner?	ospital: 1 npafier	nt 2 ER/0	Outpatient	3□ DOA Othe	20	ome 5 Resi		□Other (Spe	cify)
Ö	ig Ph ter th neral	Ľ;	27. Manner of Death	28a. Dafe of Injur (Month, Day	y 28b	. Time of	28c. Injun Worl	at	28d. Describe	how injury	occurred	
<u>.</u>	ittendin death. ctor: Afi y the fur	atic	1 Natural 5 Pending 2 Accident investigation	(		,,		Yes 2□No				
Division of Vital Records,	r Atte er de recto by th	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of Inju- building, etc		farm, stre	et, factory, office		28f. Location ( City or To	Street and wn, State)	Number or Ru	ural Route Number,
ā	ital or A irs after ral Dire led in by	Cer		ļy .								
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit	Medical	29a. Certifier in Certifying Phys (Check only one) 2 Medical Examin	ician: To the best of er: On the basis of and manner sta	examination	ige, death and/or inv	occurred at the time estigation, in my of	ne, date and place pinion, death occu	, and due to the rred at the time,	date and p	nd manner as place, and due	s stated. a to the cause(s)
	To the To the comp	Z	29b. Signature and title of certifier	4			29c. License			29d. Date	signed (Mont	
)	d		Minu Ga	NIX			DI	71165	an	20	125	-c 500-6
	11)		30. Name and address of person who co-	mpleted cause of de	-the	*		. (-	- Jan - 1/2-	0.1		ex n
لے	U		1 Ganti 10	686	Do	072	· DI	110	25-11	du	CAN	1117
W		ate	31. Date filed (Month, Day, Year)	92. Registra	ar's Signature	house	de la			2	100	Y
Divi	Regist		JUL 2 5 2006	SURPLACE	10 1					_		
UNI	MH 17 Rev 1/2	·WI										

**ORIGINAL** 

Please Type or Print in Black Indetible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene (1977) Per Dr., G857 07/25/06dhb (290. No. Reg. No. 2 Date of Death 3. Time of Death Month **Physician** 8:0Z. 2006 1 ( 2006 4c. County of Death /Medical 4b. City. Town, or Location of Death Examiner Birthplace (State or Foreign Country) (In yrs. last birthday, **Funeral** Min 1 XM 2 ☐ F 53 Yrs. 213.60.6268 Director Usual Residence of Decedent filed within 72 hours after death with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location r than "natural", or Iteme 23s or 28s-f show The Medical Examinar must be notified at 1 XYes 2 □ No MD Baltimore Director 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21212 Radnor Avenue USA 508 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status (Zes 2 No 1 Yes, Give rear or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: Black ģ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) I Hygiene. other than Ivansportation Driver 12th grade 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If ttem 27 is marked oth any jilury or other traumatic event ang. Hallie Mae Brandon Lawson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Radnor Avenue Baltimore MD 21212 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State DWIND Mills Garrison Forest 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Tyneral Services 139 Him one MD 21212 C. Greene F Orle Road 23a. Parti. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause of each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examine ate has been signed by the attending physician and page 2 should be detached for use as the burial-transit Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy Month Dav in the past 12 months?
1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ 4 Onknown 3 Probably 1 ☐ Yes 2 ☐ No Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed 2□ No 200 filled in by the funeral director, 25. Was case referred to medical examiner?
1 Yes/ 2 No Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 2 Proutpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: al or Attending P s after death. I Director: After t After 1 Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No M 2 Accident 6 Could not be determined 3 🗌 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral DI completely filled in 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature/and hitse of dertifie 29c. License number 29d. Date signed (Month, Day, Year) July 24, 2006 2

State Registrar 31. Date filed (Month, Day, Year) JUL 2 5 2006 32. Registrar's Signature 1334CLA

eath (Item 23a) (Type, Print)

			State of Maryland / D	epartment of Health an Certificate of Death	d Mental Hygie		23210
Physici /Medi	cal	Decedent's Name (First, Middle, Last)     ABRAHAM     Selith Name (If set institution size of	sect and number	BLIDEN  4b. City, Town, or Location of D		2 2006  4c. County of Death	3. Time of Death 2:22 P M
Examir Funeral Director	ner	4a. Facility Name (If not institution, give st SUNRISE OF PIKESV.  5. Social Security Number  212-01-5645  6. Sex	7. Age (In yrs. last birth	PIKESV	ILLE	BAL7	FIMORE  place (State or Foreign MD
B Maryland	ctor	Usual Residence of Decedent  10a, State 10b, County  MD BALTIN	10c. City, Town	or Location KESVILLE			10d. Inside City Limits 1 ☐ Yes 2 🂢 No
ath with the 23a or 28 ust be no	Funeral Director	10e. Street and Number 1328 GREENBRIAR C.			.208	g. Citizen of What Cou	USA
ours after des rai', or items Exeminar m	b	11. Marital Status  1  Never Married 2 Married  3  Widowed 4 Divorced	2. Was Decedent Ever in U.S. Armed Forces? 1 ☑ Yes 2 ☐ No If Yes, Give Year or Dates:	13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, P 1 □ Yes 2 ☒ No Specify:	? (Specify Yes or No- uerto Rican, etc.)	14. Race - Ameri Black, White, Specify:	
permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural; or Items 23a or 28a-f show eny injury or other traumatic event, the Medical Examinar must be notified at Angle.	Completed	15. Decedent's Educi (Specify only highest grade Elementary/Secondary (0-12)	Completed)	Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired) ROPRIETOR	working	DRY CLEANIN	
should be filed nd Mental Hygi i marked other umatic event,	To Be (	17. Father's Name (First, Middle, Last) SAMUEL		I DEN GO	LUIL	UNKNOWN	
1 and 2 sho Health and Iem 27 Is m		19a. Informant's Name/Relationship (Typ MARILYN BLIDEN /	DAUGHTER 1:	Mailing Address (Street and Number of 328 GREENBRIAR CIF	CLE - BALTI	MORE, MD 2	21208
permit. Pages 1 ar Department of Hea Importent: If Item eny injury or othe		20a. Method of Disposition  1	ARLINGT	Disposition (Name of v. crematory or other place) ON CHIZUK AMUNO 7	/24/2006	BALTIMORE	, MD
Dermi Depa Impo eny ii		23a. Part1. Enter the disease, or complic	iddle	8900 REISTERSTOW	IN ROAD - PI	KESVILLE,	
Physician /Medical Examiner		shock, or heart failure. List only one Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions.	Dementia Due to (or as a consequence of				Interval Between Onset and Death
te be executed ysician and le burial-transit	cai Examiner	Sequentially list conditions, if any, leading to introduct cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d.	Due to (or as a consequence o				
that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	ic. If yes, outcome of pregnancy  1 Live birth 2 Fetal death 4 Pregnant at time of death 9 Unknown	3 □Ectopic pregnancy 5 □ Other (specify)		23d. Date of deliv Month	ery Day Year
law requires that the as been signed by the 2 should be detache	by	Part II. Other significant conditions cont	ributing to death but not resulting in	the underlying cause given in Part I.		cco use contribute to t	
The ate h	Completed				24a. Was an autopsy performe	prior to co death?	opsy findings available impletion of cause of
Attending Physicien: The redeath. sector: Atter this certificate by the funeral director, page	ation: To Be	25. Was case referred to medical examiner? 1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	ospital: 1 Inpatient 2 ER/Out  28a. Date of Injury (Month, Day Year)  28b. T	patient 3 DOA Other: 4 Nursii	Death (Check only one)  ng Home 5 Residen  28d. Describe how	ce 6 □Other (Speci	fy)
el or Attending s after death. al Director: Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	m, street, factory, office	28f. Location (Stre City or Town,	et and Number or Run State)	al Route Number,
To the Hospital or At within 24 hours after of To the Funeral Direct completely filled in by	ledical	29a. Certifier (Check only one)  1 Certifying Phys. 2 Medical Examin	ician: To the best of my knowledge, er: On the basis of examination and and manner stated.	death occurred at the time, date and purchased death of the strength of the death of the strength of the stren	lace, and due to the cau occurred at the time, date	se(s) and manner as s e and place, and due t	stated. o the cause(s)
To the within 2 To the complete	×	29b. Signature and title of certifier	Solomon	29c. License number	. (	d. Date signed (Month,	Day, Year)
6		30. Nam , and address of person who co	ted cause of death (Item 23a) (	1838 Green	e Tree	Road	1. 21208
St Regist	ate rar	JUL 25 20		( Sall			

			1 - For State Registrar	State of Mary		artment of H			ene () () 6	23211
	Physici	-	1. Decedent's Name (First, Middle, Last)		C	horba		2. Date of Death Month	Day Year 2006	3. Time of Death 5:10 PM
}	/Medic Examin		4a. Facility Name (If not institution, give st Johns Hopkins Bayulet	1. 1	Center	4b. City, Town, or Baltim			4c. County of Deat Baltimore	city
	Funeral Director		172-10-3724	7. Age (lr	n yrs. last birthday) 85 Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, 12)	9. Bird 2, 1921	hplace (State or Foreign untry) PA.
	faryland	or	Usual Residence of Decedent  10a. State 10b. County  Maryland Baltimor		ic. City, Town or Lo					10d. Inside City Limits 1 ☐ Yes 2√ No
	with the N Is or 28a-1	Director	Maryland Baltimor  10e. Street and Number  1704 Ranch Lane	е	Durida	10f. Zip Code 21222	2	10	g. Citizen of What Co USA	
980	d within 72 hours after death with the Maryland jene. r than "natural", or Items 23a or 28a-f ehow the Medical Examination to collified at	by Funeral		2. Was Decedent Ever Armed Forces? 1 MYes 2 □ No If Yes, Give Year or Dates:		Was Decedent of Hi If Yes, specify Cuba 1 ☐ Yes 2 No	ispanic Origin? (S n, Mexican, Puerl Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ame Black, Whit Specify: Wh	e, etc.
Maryland 21215-0036	70 70 10 100	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12) 12 years	ation completed) College (1-4 or 5+)	(Give	dent's Usual Occupi kind of work done o DO NOT use retired Lerk	ation during most of wor )	rking	6b. Kind of Business Bethlehem	,
/land	s 1 and 2 should be filed f Health and Mental Hygis Item 27 le marked other other traumatic event, II	To Be C	17. Father's Name (First, Middle, Last) Joseph Krzysko					ne (First, Middle, Ma K. Mille		
_	is 1 and 2 sho of Health and I tem 27 tems other traume		19a. Informant's Name/Relationship (Type Frank Chorba	e, Print) Son		•		alk, Mary	City or Town, State, 2 Land 2122	
Baltimore,	permit. Pages 1 a Depertment of He Important: If Item any injury or oth		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State	20b. Place of Dispo cemetery, crei Gardens of	osition (Name of matory or other place Faith Cemet	ery July	Date 2006 F	Oc. Location - City or Rosedale M	Town, State aryland
Balt	Depart Depart Import		21. Signature of Funeral Service License	onne					undalk,P.A undalk,MD.	°21222
	Physician /Medical		23a. Part 1. Enter the disease or complic shock, or heart failure. List only one immediate Cause (Final disease or condition resulting in death)	Right M	liddle Cert	1 1 1	e1 1		st,	Approximate Interval Between Onset and Death
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8760,	icate be executed physicien and s the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  d. d.	Hyperte Due to (bras a co	nsign					Years
P.O. Box 68	death certifii e attending p id for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at time 9 ☐ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of deli Month	very Day Year
rds, P	sign d be	Š	Part II. Other significant conditions cont Breas+ Cancer	ributing to death but no	ot resulting in the u	nderlying cause give	en in Part I.	23e. Did toba	cco use contribute to	the cause of death?
Division of Vital Records,	The law ete has t page 2 s	Completed						24a. Was an autopsy performe	prior to death?	topsy findings available completion of cause of 2 No
Vits	Physician: Th this certificete ral director, pag	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	spital: 1. Inpatient	2 ☐ ER/Outpatier	othe Othe	20	th Check only one	a 700 to	
on of	Attending Physic death.  ector: After this by the funeral di	tion: To	27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	28a. Date of Injury (Month, Day Ye	28b. Time o	f 28c. Injury	4 🗆 Nursing 🗆	28d. Describe how	ce 6 □Other (Spec rinjury occurred	eny)
Divisi	i Sign	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (S	At home, farm, str Specify)	reet, factory, office		28f. Location (Stre City or Town,	et and Number or Ru State)	ral Route Number,
	ne Hospitel n 24 hours a ne Funeral I	edical	29a. Certifier 1 Certifying Physic (Check only one) 2 Medicat Examin	cian: To the best of m er: On the basis of exa and manner stated.	amination and/or in	vestigation, in my of	pinion, death occu	rred at the time, dat	se(s) and manner as e and place, and due	stated. to the cause(s)
)	To the within 2 To the complet	W	29b. Signature and title of certifier  (Life United States 1)	lill, M.D.		Print) Print AVE NUE	5 - 00 C	290	July 20,	
	b		30. Name and address of person who con Jeffrey Highfill, M	npleted cause of death	(Item 23a) (Type, 1940 East	Print) I'M AVEAUE	Balti	more, MD	21224	
	Sta Registr		31. Date filed (Month, Day, Year)	32/Registrar's	Signature	alle d				

		1 - For State Registrar	State of Ma	aryland		artmen tificat			and M	_	giene ,	2006	23212
Physic		Decedent's Name (First, Middle, Last)     Marie	N.		Cer	vin				2. Date of De. Month <b>July</b>	ath Day	2006	3. Time of Death 7:18 PM
/Medi Exami		4a. Facility Name (If not institution, give s	street and number)		001		Town, or	Location o	of Death	0 42 1	4c. C	ounty of Death	
		Gilchrist Cente 5. Social Security Number 6. Sex		o la ure le	act hirthday)	If I Inder	TOW 1 Year	son	24 Hrs	8. Date of Birt		Baltimo	
Funeral Director		219-22-5879	M 20XF	7	9 Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)	27 Balti	olace (State or Foreign ntry) More, Maryland
/land ow		Usuel Residence of Decedent  10a. State  10b. County		10c. City	, Town or Lo	cation							10d. Inside City Limits
ith the Marylan or 28a-f ehow	ctor	Maryland N/A		Ba	ltimor	re							1 <b>X</b> Yes 2 ☐ No
	Funeral Director	10e. Street and Number 4605 Luerssen Aver	iue			10f. Zip	Code 21206	5			10g. Citize	en of What Cou	ntry?
er death	unera		12. Was Decedent Armed Forces?		S. 13. \	Was Deced	dent of Hi	spanic Orig n, Mexican	gin? (Spec , Puerto F	cify Yes or No Rican, etc.)	- 14	I. Race - Ameri Black, White,	
72 hours after death w "natural", or iteme 23a	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 2 🛣 If Yes, Give Year or Dates:	No		1 □ Yes	2 <b>⊠</b> No	Specify:			s	Specify: Whi	ite
n 72 ho	Completed	15. Decedent's Educ (Specify only highest grade	ation completed)		16a. Deced	ient's Usua kind of wo	al Occupa rk done d	ition furing most	t of workin	g	16b. Kind	d of Business/In	dustry
d withii giene. or then	omo	Elementary/Secondary (0-12)  12 years	College (1-4or 5	5+)	Law E					1	Balt	imore (	City
I be file ntal Hy ed oth	Be	17. Father's Name (First, Middle, Last)  George F. Zech								(First, Middle, White	Maiden S	umame)	
should Ind Men	10	19a. Informant's Name/Relationship (Ty)	ое, Print)		19b. Mailir	ng Address	(Street a				er, City or	Town, State, Zip	Code)
and 2 ealth a m 27 is		Deborah A. Uhlik	Daugh		<del></del>			Stree				aryland	
Pages 1 nent of Hi ant: if iter		20a. Method of Disposition  1 □ Burial 2 ▼Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	emoval from State	ce	ace of Dispo metery, crem View (	natory or o	ther place	9)		7 24,		ation-City or To Lmre Cit	
permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Importent: if item 27 is marked other then any injury or other traumatic event, the Magnes.		21. Signature of Funeral Service License	18	- 11	<i></i>			s of Facility				alk, P.A.	
a go e a d		23a. Part1. Enter the disease, or compli	cations that caused	the death.	1	110 5	SO116	ers Po	oint	Road,	Dunda	alk,MĎ.	21222 Approximate
Physician /Medical Examiner		shock, or neart failure. List only on Immediate Cause (Final disease or condition resulting in death)	Due to (or as	ne. UV	a (	7	1ce						Interval Between Onset and Death
ate be executed hysicien end A hysicien he burial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as										
To the Hospitel or Attending Physicien: The law requires that the death certificate be executed within 24 hours alter death. To the Funeral Director: After this certificate has been signed by the ettending physicien end on publication in by the funeral director, page 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 mgpths? 1   Yes 2   No 9   Unknown	3c. If yes, outcome 1 Live birth 4 Pregnant at 9 Unknown	2 Fetel	death 3	Ectopic pr					23	d. Date of delive	ery Day Year
quires that in signed by	þ	Part II. Other significant conditions con	tributing to death b	$\gamma$ /	Iting in the ur		ause give	n in Part I.				-	he cause of death?
Physicien: The law requir this certificate has been siral director, page 2 should	Completed									24a. Was autop perfo 1 Yes	rmed?	24b. Were auto prior to co death? 1 □ Yes	psy findings available mpletion of cause of 2 No
ysicien: Th ysicien: Th s certificate director, pag	To Be	25. Was case referred to medical examiner?	ospital:	ent 2 🗆 E	ER/Outpatien	t 3 🗆 DC	Othe	c		(Check only o		₫Other (Specif	w Has vice
ath.		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Inju (Month, Da		28b. Time of Injury		8c. Injury Work		2	8d. Describe h			1103/1Q
To the Hospitel or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, etc.	ury - At hor c. (Specify)	me, farm, str	eet, factory	, office		2	8f. Location (S City or Tox	Street and I vn. State)	Number or Rura	al Route Number,
Hosp 24 hou Fune.	Medical	29a. Certifier 1 Certifying Physical Check only 2 Medical Examination	ician: To the best ner: On the basis of and manner sta	f examinati	vledge, death ion and/or inv	occurred restigation	at the tim , in my op	e, date and inion, deat	d place, at th occurre	nd due to the o d at the time,	cause(s) ar date and p	nd manner as s lace, and due to	tated. the cause(s)
To the within To the compl	Me	29b. Signature and title of certifier	1-0				. License					signed (Month,	
1.		If Anthon	7 Rele	710	us -	1	ن لور	30	7		July	, 20, 8	2006
り		30. Name and address of person who co	GBME	670	( N-	Chr.	ele.	St	6	alto.	nd	20,8	205
St Regist	ate trar	31. Date filed (Month, Day, Year) /	32. Registra	ar's Signati	to fig	MILL OF							

# Please Type or Print in Black Indelible Ink

randon Comma	1	1- For State Contificate of Death	eg No. 2006 2321									
Physicia	ın/	1. Decedent's Name (First, Middle,Last)  2. Date of Deat Month	th 3. Time of Death									
Medical Examine		Brandon  Gommander  July 20, 20  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death	1546 hrs									
		University Hospital  Baltimore	ite. Osamy of Beating									
Funeral		7,	th(MM/DD/YYYY) 9. Birthplace (State or									
Director		218-71-9652   1 XM 2 F   1 Yrs.   Months   Days   Hours   Min.   O2 2	6 05 Foreign Country) MD									
any	L-	Usual Residence of Decedent  10a State 10b. County 10c. City, Town or Location	10d. Inside City Limits									
<u> </u>	- 1	MD NA Baltimore	1 X Yes 2 No									
Maryland 28a-f show d at once.	Director	10e. Street and Number 10f. Zip Code 11	Og. Citizen of What Country?									
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once.			U.S.A.									
ath wit	Funeral	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.									
fter des			Specify Black									
nours a	ed by	Ior Dates:  15. Decedent's Education (Specify only highest grade completed)  during most of working life. DO NOT use retired)	16b. Kind of Business/Industry									
36 iin 72 l han ", dical F	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  N/A  N/A  N/A	N/A									
d with	E	N/A N/A N/A  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, N										
21215-0036 build be filed within 7 Mental Hygiene. marked other than c event, the Medica	Be	👸 Jonathan Commander Crystal DiAn										
D 21 should and Me aric ev	2											
and 2 sealth a tem 27	Н	Crystal Commander-Mother   2244 Cedley Street, Balt  20a Method of Disposition   20b Place of Disposition (Name of cemetery,   Date	20c. Location - City or Town, State									
10re		1 X Burial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify.  King Memorial Park 7/27/06	Randallstown, Md									
altin nit. Pa partmet portan	1	4 Donation 5 Other Specify King Memorial Park //2//06  21. Sunature of Funeral Service Lice se  22. Name and Address of Eacility arch F/H West	Randalistown, Md									
E D D E		14300 Wabash Ave, Baltimore, Md 21215										
Physician /Medical		failure. List only one cause on each line.	est, shock, or heart Approximate Interval Between Onset and Death									
Examiner		Immediate Cause (Final disease or condition resulting in death)  Dehydration and environmental hyperthermia  Due to (or as a consequence of):	Deali									
		Sequentially list conditions, b										
	ine	if any, leading to immediate Due to (or as a consequence of):										
ed Isit	Examiner	Cubsease or injury that initiated events resulting in death) Last cube (or as a consequence of):	74 (2)									
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after cleath.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	call	d.										
760, icate be exe physician a	Medical	#23a,27,28a-f, per Me, g862, 12/1/06 TT  #FFEMALE:  23c. If yes, outcome of pregnancy  23b. Was decedent pregnant in the	23d. Date of delivery									
687 sertific ding p	ian/	Month Day Year										
Box 687  re death certific  the attending red for use as the	Physician/	4 Pregnant at time of death 5 Other (Specify) 9 Unknown										
Division of Vital Records, P.O. B rothe Hospital or Attending Physician: The law requires that the daminin 24 hours after death.  To the Funeral Director: After this certificate has been signed by the completely filled in by the funeral director, page 2 should be detached.	by Ph	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	obacco use contribute to the cause of death?									
Division of Vital Records, P.O. tal or Attending Physician: The law requires that the safter death.  al Director: After this certificate has been signed by led in by the funeral director, page 2 should be detach.	ed b	1 Yes 24a Was:	an 24b. Were autopsy findings available									
cord law red has bed 2 shou	Completed	autop										
Rec The ficate	S	1 V yes										
'ital sician: is certi lirector	Be	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 FR/Outpatient 3 DOA Other Nursing Home 5	Residence 6 Other									
of V g Phy fter th	2	27. Manner of Death 28 Date of Injury (Month, Day,Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe 1	how injury occurred									
ion tendin eath.	atior	Natural 5 Pending Investigation Find 7/20/2006 Find 3:00 pm 1 Yes 2 X No unknown										
ivisior or Attendate death	Certification	28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (sor Town, Sor	et and Number or Rural Route Number, City 2244 Cedley Street									
D ospital hours uneral y fillec	Se	4 Homicide determined (Specify) residence Baltimor	e, MD									
To the Hospital within 24 hours	Medical	29a. Certified 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the caus (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date	and place, and due to the cause(s)									
To Wight	Me	and manner stated 1  29b. Signature and title of certifier 29c License number 29d. Date signed (Month)										
		O.C.M.E.	July 21, 2006									
		30. Name and address of person who completed cause of death (Item 23a)  Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201										
	tate	Log Davidude Circular										
Regis												
DHMH 17 Rev 1/2	2001	ORIGINAL.										

			For State Registrar	State of Mary	yland /				ealth a	and M		Reg. No	Z 11111		23214	_	
	Physicia	an	1. Decedent's Name (First, Middle, Las								2. Date of De Month	Da			. Time of Death		
	/Medic		Margaret Rose Far		t					(-)		1			1:30p M	_	
	Examin	er	4a. Facility Name (If not institution, give 4650 Davis Avenue				4b. City,		Location o	of Death			4c. County of Death Prince George's				
			5. Social Security Number 6. Se		n vrs. last h		If Under		If Under 2	24 Hrs.	8. Date of Bir				State or Foreign	-	
	Funeral Director			□M 2120 F	n yrs. last b	Yrs.	Months	Days	Hours	Min.	(Month, Da	y, Year)		ountry) 1an			
			Usual Residence of Decedent													_	
13-UU30 172 hours after death with the Maryland "neturel", or Hems 23a or 28a-f show	show		MD 10b. County Prince G		Oc. City, To Suitla		ation							1	Inside City Limits 1		
	8a-f.	cto		corge 5	,u1010		T				1			1		_	
	vith th	Funeral Director	10e. Street and Number 4650 Davis Avenue 10f. Zip Code 20746									ountry?	!				
	erai	4650 Davis Avenue	12. Was Decedent Eve	ar in IIS	13 W	1		isnanic Orio	nin? (Spe	cify Yes or No	USA	14. Race - Am	erican I	Indian.	_		
ter d		F	11. Marital Status 1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ♣No	, iii 0.0.				n, Mexican	, Puerto	cify Yes or No Rican, etc.)		Black, Wh	ite, etc.			
2-UUSO 72 hours after neturel; or ite	ors a	þ	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			1 ☐ Yes 2 🕱 No Specify:						Specify: White				
	Completed	15. Decedent's Ed (Specify only highest gra		16	a. Decede	ent's Usu	al Occupa	ation during most	t of worki	ng	16b. K	ind of Busines	s/Indust	try			
7	within 72 ene. than "ne.	μpi	Elementary/Secondary (0-12)	College (1-4or 5+)	1	life. D	O NOT u	se retired	1)			D.	1				
V	led w tygier her t		17. Father's Name (First, Middle, Last)		ľ	lall	Orde	r Mai	nager	r's Name	(First, Middle		ostal			-	
	od of	Be	Albert Farnie								Dodds	, maidon	Garriamo,				
	should ad Men marke matic	မှ	19a. Informant's Name/Relationship (7	ype, Print)	19	9b. Mailing	g Address	(Street a	and Numbe	or or Rura	l Route Numb	de)	-				
<u> </u>	s 1 and 2 should f Heelth and Mer Item 27 is marke other traumatic		Marina Crockett/d	aughter	4	4650	Davi	s Av	e.Sui	t1an	d, MD 2	20746	5				
ē,	os 1 and 3 of Heelth item 27 r other tr		20a. Method of Disposition		20b. Place ceme	of Dispos	ition (Na	ne of other plac	:e)	С	ate	20c. L	ocation - City o	r Town,	State	-	
Ē	W - = =		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Chesa					7-22	-2006	Be1t	sville	, MI	D		
Baitimore	permit. Peg Department Important: I any injury c once.		21. Signature of Funeral Service Licen		_	22. D.a	Name ar	nd Addres	ss of Facilit	у С	Silver	Spi	ing MD	209	910		
П	805 8 8			2 moi358									933 G1S			_	
			23a. Part1. Enter the disease, or companies of heart failure. List only	one cause on each line.										Int	proximate erval Between nset and Death		
1	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)  a. Left Briast Carcinoma with metastosis (final metastosis)											Lypen			
	Examiner			Due to (ovas a co	consequence	:e of):									Ø		
		er	Sequentially list conditions, if any, leading to immediate	Due to (by as a co	onsequence	e of):										-	
	outed sd ransit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):									1					
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	cate b	dicai		d							-					_	
R9 X	death certificat e attending phy of for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcome of p	pregnancy								23d. Date of d	alivary			
X P O	atten for u	cian	in the past 12 months?    Company										Month Day Year				
o.	0 0	nysi	1 ☐ Yes 2 D No 9 ☐ Unknown	9□ Unknown												_	
v.	faw requires that the de- es been signed by the a 2 should be detached f	by P	Partition of Symmon Conditions Continuously to about the resoluting in the disconying cause given are access								23e. Did	tobacco	acco use contribute to the cause of death?				
Hecords,	w require been sig should b	pa									10	1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Munknow					
ပ္ပ	e taw re hes be je 2 sho	Completed									24a. Was	Was an 24b. Wer prior		e autopsy findings available to completion of cause of			
-	Page 1	Co									perf 1 ☐ Yes	ormed? 2 <b>X</b> No	death?		] No		
Vital	ysicien: Th nis certificete director, pag	Be	25. Was case referred to medical examiner?	Hospitali								eath (Check only one)					
ing Phys	S S S	٦.	1 ☐ Yes 2 ☐ No  27. Manner of Death	1 Lempatient				JA	4 🗆 140				e 6 ☐Other (Spe			_	
	ing one	tion	1 Natural 5 ☐ Pending	(Month, Day Year)		Injury	28c. Injui Wo		rk? ]Yes 2 □No				many seed to				
1151	l or Attending efter death. Director: After in by the fune	fica	3 Suicide 6 Could not be 28e, Place of Injury - At home, farm, street, factory, office							-	28f. Location (Street and Number or Rural Route Nul City or Town, State)						
á	i 등 등 등	Certification:	4 Homicide	building, etc. (	Specify)						City or 10	wn, State	Β/				
	To the Hospitel or within 24 hours efte To the Funeral Diracompletely filled in It	edical	29a. Certifier  (Check only one)  29a. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.											d. e cause(s)			
	within 2 To the complet	Me	29b. Signature and title of certifier				1	29c. License number				29d. Date signed (Month, Day, Year)					
)			D. Rosans	P. Jamon	Re			219	518			7/21/06 C4WTON, MD. 20735					
	6		30. Name and address of person who	completed cause of deat	th (Item) 23	a) (Type, I	Print)	1							-		
			31. Date filed (Month, Day, Year)	RNGN) EZ  Registrar's	+70	0 02	1) (3)	KANK	-H A	ve.	402 (	41	אטדיי	y.	20135	_	
*	Sta Registi		.1111 2 5 200	6 Ke	M	Ana	1. 5										

DHMH 17 Rev 1/2001

State of Maryland / Department of Health and Mental Hygiene [] [] [ Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day 11:05AM **Physician** dward July 21,2006 7 2 S /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Kehab. lutation and Extended Care Baltimore N/A Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | AUG 26 1920 9. 8irthplace (State or Foreign Country) WI 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1[XM 2□ F 85 **477-14-**8**57**0 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b. County show r then "naturel", or Iteme 23a or 28a-f show the Medical Examinar must be notified at 1 ☐ Yes 2 No Completed by Funeral Director Nottingham MD Baltimore with the 10g, Citizen of What Country? 10f. Zip Code 10e. Street and Number USA 21236 Apt. T1 1 Harebell Court, permit Pages 1 and 2 should be filed within 72 hours atter death v Department of Health and Mental Hygiene. Important: If item 27 is marked other than 'natural', or iteme 28s any injury or other fraumatic event, the Medical Example of these 12. Was Decedent Ever in U.S. Armed Forces? 1 XYes 2 No If Yes, Give WWTT Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 X Married 21215-0036 1 Yes 2 No Specify: Specify: white If Yes, Give Year or Dates: WWII 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Auto Mechanic Automobile 12 18. Mother's Name (First, Middle, Maiden Sumame) Baltimore, Maryland 17. Father's Name (First, Middle, Last) Be Rose Salonek Cerves Joseph 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Glenamoy Court, Unit 302, Lutherville, MD 21093 Donald B. Ceryes - son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 【Cremation 3 ☐ Removal from State Chesapeake Crematory 7/22 2006 Beltsville, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses CAFA, Stephen D. Lohrmann, PA 8717 Green Pastures Drive, Towson, MD 21286 M00986 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between set and Death Immediate Cause (Final disease or condition resulting in death) Multi-infarction Physician years /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner the attending physicien and the for use as the burial-transit requires that the death certificate be executed Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown ል Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy 1 Yes 2 PNo To the Hospital or Attending Physician: within 24 hours after death. To the Funerel Director: After this certifice 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28b. Time of Injury 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification; 27. Manner of Death 1 Natural 5 Pending 1 ☐Yes 2 ☐ No investigation 2 Accident filled in by the 3 ☐ Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 1 Fortifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. 29b. Signature of title of certifier 29d. Date signed (Month, Day, Year) 00032548 30. Name and address of green who completed cause of death (Item 23a) (Type, Print) Greene Street. 10 North Cilv 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2 Date of Death Day 2006 11PM **Physician** 1RU50 PRNICE 20 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner TUSP ISALTIMORE If Under 1 Year | If Under 24 Hrs. 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number **Funeral** Days 1 ☐ M 2 🔀 F 80 Yrs. 216-20-5478 Director 7-17-1926 Phila.PA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rithen "naturel", or iteme 23s or 28s-f ehovithe Wedical Examiner must be notified at 1 Yes 2 No MD Baltimore Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2101 A Creek Road 21219 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. filed within 72 hours after 1 ☐ Yes 2 🔀 No If Yes, Give Year or Dates: 1 Never Married 2X Married Maryland 21215-0036 Specify: White 1 ☐ Yes 2 X No Specify: ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Office Clerk City of Baltimore 12th of Health and Mental Hygie If Item 27 Ie marked other I or other traumatic event, to 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be UNK UNK Taraskewicz 19a. Informant's Name/Relationship (Type, Print) husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) if item 27 i 2101-A Creek Rd. Baltimore, Maryland 21219 Rocco Caruso altimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State ò 7/25/2006 Baltimore, MD Department in important: if any injury or once. St. Stanislaus 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. FH 21. Signature of Funeral Service Licenses 263 S. Conkling St. Baltimore, MD 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only the cause on each line. Immediate Cause (Final disease or condition resulting in death) MOHARY Mbolism Physician Mixutes /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Physician/Medical the attending pt for use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Dav Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown 9 ☐ Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by LISEALE 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Nonknown 24b. Were autopsy findings available prior to completion of cause of death? eronge autopsy COPI performed? 1 Yes 20 No 1 ☐ Yes 2 ☐ No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one)

P.O. Box 68760, of Vital Records, certificate has been signe rector, page 2 should be director. After the funeral Division within 24 hours after death.

To the Funeral Director: A
completely filled in by the fu

0

State

Medical Certification: To

05N4 31. Date filed (Month,

29b. Signature and title of certifier

5 Pending investigation

6 ☐ Could not be

1 ☐ Yes 2 No

27. Manner of Death

Natural

2 Accident

3 Suicide

29a. Certifier

4 Homicide

USLA

28a. Date of Injury (Month, Day Year)

29c. License number

1 ☐ Yes 2 ☐ No

28c. Injury at Work?

1 Scertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 501

BACTIMORE PULCE

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

32. Registrar's Signature

Impatient 2 ER/Outpatient 3 DOA

Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28b. Time of

Please Type or Print in Black Indelible Ink

ames Carr		For State	of Maryland		rtment of tificate of			Mental	І Нуд		Reg. <b>N</b> o	20	06 2321
Physician Medical Examine	1	egistrar . Decedent's Name (First, Middle,Las James J	ospeh	Carr					1	Date of Dea Month July 22, 2	ath Day	Year	3. Time of Death 1520 hrs
	4	a. Facility Name (if not institution, given Northwest Regional Hosp			4	b. City, To Randa		ocation of D	eath			unty of Dea imore Co	
Funeral Director	5	. Social Security Number 6. S 213-82-9568		e (In yrs. la 47	ast birthday) Yrs	If Under Months		If Under 2 Hours			, 1959	Fore	Birthplace (State or eign Country) MD
Maryland 28a-f show any ft at once.	1	Sual Residence of Decedent   10b. County   MD   Baltimo	re	1	Town or Locati					-		·	10d Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f sho notified at once	1	0e. Street and Number 105 3rd Avenue		,		10f. Zip ( 21]					10g. Citizen U.S.A		ountry?
er death wi	<u>-</u>  2	1. Marital Status 1. Never Married 2. Married 3. Widowed 4. Divorce 15. Decedent's Education (Specify of	1 Yes 2 If Yes, Give Year or Dates:	X No		es, specify	Cuban, I	Mexican, Pu	uerto Ri		Spe	White, etc.	erican Indian, Black,  Vhite  s/Industry
Tore, MD 21215-0036  gges 1 and 2 should be filed within 72 hours aft at Greath and Mental Hygiene.  1: If item 27 is marked other than "natural" other traumatic event, the Medical Examine To Be Completed by	nanaidiii	Elementary/Secondary (0-12)	College (1-4 or		during m Constr		n Su		nten	dent		struct	ion
D 21215-0036 should be filed within 7 and Mental Hygiene. 7 is marked other than natic event, the Medical TO Be Comple	i i	7. Father's Name (First, Middle, Las Dr. Charles E. C 9a. Informant's Name/Relationship (	arr, Jr.,	MD	19h Mailine	Address		Mary	Ade	le We			ate, Zip Code)
MD 21 nd 2 should alth and Mer nn 27 is man aumatic ev		Michelle A. Carr									n, MD		
ore, North		Ca. Method of Disposition	Removal from St		Place of Dispos crematory or ot		e of ceme	etery,	Į	Date	20c. Loca	ation - City	or Town, State
Baltimore, permit. Pages 1 ar Department of He. Important: If ite injury or other tr		4 Donation 5 Other Specifi	/:		aney Va					′-06	Timo eral H	nium,	
Bali permit Depar Impor		21. Signal re of Forneral Servic Lice	4/:										own, MD 21136
Physician /Medical		23a. Part I. Enter the disease, or com failure List only one cause on e mmediate Cause (Final disease					dying, s	uch as card	liac or r	espiratory a	rrest, shock,	or heart	Approximate Interval Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a cons										
	III III III III III III III III III II	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a cons										
to, the executed system and burial - transit	edical Ex		AMENDED	#10	HI C	050.0/	0/00	(III)		<del></del>			
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Box 6876 e death certificate the attending phy ed for use as the l	Physician/M	3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknow	1 Live birth 4 Pregnant a  9 Unknown	t time of de	- 44	etal death ther (Spec	3 _ ify)	Ectopic p	regnand	cy	Мо	inth	Day Year
res that the d signed by the be detached	ਨ∥	Part II. Other significant conditions	contributing to deal	th but not r	esulting in the	underlying	cause giv	ven in Part	l.				to the cause of death? robably 4 Unknown
Division of Vital Records, P.O. Box 6876( To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physicompletely filled in by the funeral director, page 2 should be detached for use as the beau page 2 should be detached for use as the beau page 2 should be detached for use as the beau page 2 should be detached for use as the beau page 2 should be detached for use as the beautiful page 2 should be detached for use as the beautiful page 2 should be detached for use as the beautiful page 2 should be detached for use as the beautiful page 2.	Completed								_	1 Yes	s an opsy formed? 2 V No	prior t death	autopsy findings available o completion of cause of ? Yes 2 No
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on of Vit anding Physic tth. r: After this ne funeral dir	tion: To	1 V Yes 2 No  27. Manner of Death  1 V Natural 5 Pending	28a Date of Inj (Month, Day,		28b. Time of			at Work?		8d. Describe	e how injury	occurred	
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Di  To the Hospital within 24 hours a To the Finneral I completely filled	<u></u>		cian: To the best of r er:On the basis of exa and manner stateg										
	Me	29b. Signature and title of tertyler	V/	1		290	O.C.N					e signed <i>(1</i> 3, 2006	Month, Day,Year)
Q	-	30. Name and address of person wh Susan Hogan MD. As	o completed cause of sistant Medical E			nn Stree	t, Baltir	more, MI	D 212	01			
Sta Registr	te	31 Date filed (Month, Day, Year) JUL 25 2	32 <b>S</b> egistr	ar's Signat	ture f	ne							

			Please Type or Print in Black In		•	_	
			1 - For State of Maryland / Dep Registrar Ce	artment of Health and I rtificate of Death	Reg	ene2 0 0 6	23218
Ī	Physicia /Medic		1. Decedent's Name (First, Middle, Last)  Alfred Paul Chenoweth		0	Day Year 21 2006	<del></del>
	Examin	er	4a. Facility Name (If not institution, give street and number)  SINAI HOSPITAL OF BALTIMORE	4b. City, Town, or Location of Death BALTIMORE		4c. County of Death	
Ī	Funeral Director		5. Social Security Number 219-10-2656 6. Sex XXM 2 F 7. Age (In yrs. last birthday 82 Yrs.		8. Date of Birth (Month, Day Y June 21	, 1924 Mai	place (State or Foreign Cyland
	yland how		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L	ocation			10d. Inside City Limits
	the Ma 28a-f s	Director	MD Baltimore Reist	cerstown 10f. Zip Code	100	J. Citizen of What Cou	1 ☐ Yes 2X☐XNo
	th with 23a or	al Dir	10 Cherry Hill Court	21136		U.S.A	
38	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Medical Examinat must be notified at once.	by Funeral	11. Marital Status  XX Never Married 2 Married  3 Widowed 4 Divorced  12. Was Decedent Ever in U.S.  Amed Forces?  XY Yes 2 No. WW II  Year or Dates:	Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puert 1 ☐ Yes XX No Specify:	pecify Yes or No- o Rican, etc.)	14. Race - Ameri Black, White, Specify: Wh	
21215-0036	ithin 72 hou Ne. Nedical E	Completed	(Specify only highest grade completed) (Givilife.  Elementary/Secondary (0-12) College (1-4or 5+)	edent's Usual Occupation e kind of work done during most of wor DO NOT use retired)	king 16	BGE	ndustry
d 21	filed w Hygier other th	e Cor	1.2 M 17. Father's Name (First, Middle, Last)	eter Reader 18. Mother's Nan	ne (First, Middle, Ma		
Maryland	should be and Mental marked o umatic eve	To Be	Alfred Chenoweth	De1			
Zar	and 2 sho ealth and m 27 is m		, , , , ,	ing Address (Street and Number or Ru Coyle Road; O			
ore,	es 1 ar of Hea of Hea of Item 3		20a. Method of Disposition  20b. Place of Disposition  20b. Place of Disposition  20b. Place of Disposition  20b. Place of Disposition  20b. Place of Disposition	osition (Name of ematory or other place)	Date 20	c. Location - City or T	own, State
altimore,	nit. Pages estment of ortant: If It injury or o		4 □Donation 5 □Other (Specify) MD. Vete	rans Cemetery 22. Name and Address of Facility EC		Owings M uneral Ch	
Ba	permit. Depertra		Melas prom	1605 Reistersto	wn Rd. Ow	ings Mill	ls,MD21117
			23a. Part1. Enter the disease, or complications that caused the death. Do not en shock, or heart failure. List only one cause on each line.  Immediate Cause (Final		or respiratory arres	t,	Approximate Interval Between Onset and Death
	Physician /Medical		disease or condition resulting in death)  SEPTICEM  Due to (or as a consequence of):	14			3 WKS
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	e executed sien and urial-transit	Examiner	cause. Enter Undertying Cause (Disease or injury that initiated events  c.			-	
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	that the death cer ed by the attendir detached for use	Completed by Physician/Medical	in the past 12 months?  1  Yes 2 No	□Ectopic pregnancy □ Other (specify)		Month	Day Year
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ords	w requires t been signe should be	ted b	DIABETES MELLITUS		1 ☐ Yes	2 No 3 □ Pro	bably 4 □Unknown
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sion	Attending r death. ector: After by the fune	catlor	1	Work? M 1 □ Yes 2 □ No			
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	To the within 2 To the complet	Med	29b. Signature and title of certifier	29c. License number	290	d. Date signed (Month,	, Day, Year)
)	Λ		30. Name and address of person who completed cause of death (Item 23a) (Type	RES 000		'ULY 21	
	4		PRITAM NEUPANE SIN		of BA	ALTIMO	RE
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6	Physici	Min a	1. Decedent's Name (First, Middle, Last)  Minnie A.	Duarte						2. Date of D Month	eath Day 2 3	Yea . 20	ar	3. Time of Death 08:584	4.
*	/Medio Examir		4a. Facility Name (If not institution, give so Union Hospital	treet and number)			Town, or Lktor	Location o	f Death	July	4c.	County of De	-		<u>'</u>
	Funeral Director		3 13 10 332 1	м 2 <b>Д</b> F 6	n yrs. last birthday) 8 Yrs.	If Under Months	1 Year Days	If Under 2 Hours	Min.	8. Date of Bi (Month, D Jan.5,1	ay, Year)		Birthplac Country agler	ce (State or Fore () AR	∌ign
	Maryland	tor	Usual Residence of Decedent  10a. State 10b. County  MD Cecil	10	Oc. City, Town or Le								10d	. Inside City Lim	
	a or 28	Dire	10e. Street and Number 11 Halls Lane			10f. Zip	Code 2192	21			10g. Citiz	zen of What	Country	1?	
920	be filed within 72 hours after death with the Maryland nat Hygiene. ed other then "natural", or flems 23a or 28a-1 ehow event, it e Medical Evanicar must be profiled at	by Funeral Director	11. Marital Status 1 1 Never Married 2 Married 3 Widowed 4 Divorced	2. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates:	1	Was Deced If Yes, spec		spanic Orig n, Mexican Specify:	gin? (Spe , Puerto I	city Yes or N Rican, etc.)	0-	14. Race - Al Black, W Specify:		c.	
Maryland 21215-0036	f within 72 ho piene. r then "natur r ne Medical	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)		(Give	dent's Usua kind of wo DO NOT us	rk done d se retired)	uring most	of worki	ng		nd of Busine Cking		,	
land;	ould be filed Mental Hygis arked other i	To Be C	17. Father's Name (First, Middle, Last) Florence Olen	Gill					r's Name nice	(First, Middle Louis		Sumame) ames			
Mary	nd 2 shoulth and 27 is m		19a. Informant's Name/Relationship (Type Joseph Duarte /Hus	*		-				I Route Numb		Town, State	e, Zip C	ode)	
Baltimore,	Pages 1 and innent of Health ant: If Itam 27 ury or other tr		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Read 4 ☐ Donation 5 ☐ Other (Specify)		20b. Place of Dispo cemetery, cre Highland M	matory or o	ther place		7/20	ate 9 0 6		cation - City age Gro			
Balt	permit. Pages Department of I Important: If Its any injury or o once.		21. Signature of Furieral Service License	9	2		les L.	Steve	ans F∖	neral H					
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8760,	cate be executed obly sician and the burial-transit	Ical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a c											
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Φ.	quires that in signed b uld be deta	by	Part II. Dther significant conditions con	tributing to death but r	not resulting in the u	underlying o	ause give	n in Part I.						cause of death?	
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Vita	Physician: This certificate ral director. p	Be	25. Was case referred to medical examiner?	ospital:	-M		Othe	E		(Check only					
of	fter fter	atlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Y	2 X ER/Outpatie 28b. Time of Injury		28c. Injury Work	4 🗆 190	2	πe 5 ☐ Res 28d. Describe		_	pecify)		
Division	5 9 15 E	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	- At home, farm, st (Specify)	reet, factor	y, office				(Street and own, State)		Rural F	Route Number,	
	e Hospital 24 hours a e Funeral I	Medical	29a. Certifier 1 Certifying Physical Control (Check only one) 2 Medical Examination	ician: To the best of reference on the basis of example and manner states	camination and/or in	th occurred nvestigation	at the tim	e, date and inion, dea	d place, a	and due to the ed at the time	cause(s) , date and	and manner place, and c	as state	ed. ne cause(s)	
	To the within 2 To the complet	Me	29b. Signature and title of certifier  A Jornas	MD			C. License		14			e signed (Mo			
	10		30. Name and address of person who could Farkas MD	mpleted cause of deal	th (Item 23a) (Type	Print)	FIKT	on.	1	D					
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	32. Begistrar's	Signature	200.0									

DHMH 17 Rev 1/2001

			For State Registrar	State	of Marylar		artment of rtificate of		ınd Men		giene Reg. No.	006	23220
	Physici		1. Decedent's Name (First, Midd	tle, Last)						Date of De Month <b>ul</b> y		200 <sup>Year</sup>	3. Time of Death
	/Medic			dward	Drury,	Sr.				иту			05:16 a <sup>M</sup>
	Examin	er	4a. Facility Name (# not institution GREATER BALTI			TER	4b. City, Town, TOWSON	or Location of	f Death			unty of Death LTIMORI	Ξ
	Funeral		5. Social Security Number	6. Sex	7. Age (In yrs.		If Under 1 Year		24 Hrs. 8. [	Date of Birt	th Voorl	9. Birthp	place (State or Foreign
	Director		217-14-9415	1 <b>∑</b> M 2□F	82	Yrs.	Months Days	Hours	Min. De	Month, Da $$	1923	Mary	land
	pg .		Usual Residence of Decedent  10a. State 10b. Count	v	10c. Ci	ity, Town or Le	ocation	·	<u>.                                    </u>			1	0d, Inside City Limits
	Aaryla Fehor	ō		, timore			nium						1 ☐ Yes 2 📉 No
	the Marylan r 28a-f ehow notified at	rect	10e. Street and Number	CIMOTE		TIME	10f. Zip Code				10g. Citizen	of What Cour	ntry?
	death with the Maryland rme 23s or 28s-f ehow	Funeral Director	1 Lough Mask Co	ourt, #20	2		210	93			U	ISA	
83	lteme 2	mer	11. Marital Status	12. Was De	ecedent Ever in U Forces?	J.S. 13.	Was Decedent of If Yes, specify Cu	Hispanic Orig ban, Mexican,	gin? (Specify , Puerto Rica	Yes or No n, etc.)	- 14.	Race - Americ Black, White,	ean Indian, etc.
?≅	s after , or Ite	by Fu	1 Never Married 2 Ma 3 Widowed 4 Divorce	If Yes.	s 2 □ No Give · Dates: <b>1943</b> .	116	1 □ Yes 2 🛱 No	Specify:			Spe	ec <i>ify:</i> τ.π	nite
<b>= 8</b>	tural stural	ed t	15. Decede	nt's Education	12,13	16a. Dece	dent's Usual Occu	pation			16b. Kind o	of Business/In	
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Z Z	hould d Mer mark matic	ဥ	J.E. Drury  19a. Informant's Name/Relation	shin (Type Print)		19b. Maili	ng Address (Stree	Nor		Mora:		own. State. Zin	Code)
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more,	is 1 at of Hea Item		20a. Method of Disposition		20b.		osition (Name of matory or other pl		7/25/06			ion - City or To	own, State
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			23a. Part1/ Enter the disease, of shook, or hear failure. List	st only one cause o		3			_				Approximate Interval Between Onset and Death
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ŏ	h cert	M/U	IF FEMALE: 23b. Was decedent pregnant		outcome of pregr e birth 2 Pet		⊒Ectopic pregnan	cv			23d.	. Date of delive	•
B	e deat he att	sicia	in the past 12 months? 1 ☐ Yes 2 ☐ No		egnant at time of		Other (specify)					Month	Day Year
9	hat the	Phy	9 Unknown Part II. Other significant condi	tions contributing to	death but not re	sulting in the	underlying cause o	sven in Part I.		23e. Did t	obacco use	contribute to t	he cause of death?
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ita	ian: rtifica ctor, p	BeC	25. Was case referred to medic examiner?	cal				26. Place	of Death (Ci				7
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(	HX		30. Name and address of person	on who completed c	ause of death (Ite	am 23a) (Type	, Print)	11 0	, ;	1-	17		
	-01	210	31. Date filed (Month, Day, Yea	5700°	2. Begistrar's Sign	nature 6	101	101	دلرد	×-162	٠ ,		
	Regist	ate rar	JUL 2	on who completed c STNO ar) 32 5 2006	Colum	15. P	series						

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene Fredrick Robert Dieter 1. For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Da July 20, 2006 0502 hrs Medical Examiner 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (if not institution, give street and number **Baltimore County** 4 Punte Lane Essex 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or If Under 1 Year If Under 24Hrs. 5. Social Security Number 6 Sex 7. Age (In yrs last birthday) **Funeral** Foreian Months Davs Hours Director Country) 1 V M 2 F 21492 2595 Usual Residence of Decedent 10d Inside City Limits 10b. County 10c. City, Town or Location 'n 10a. State s 23a or 28a-f show e notified at once. 1 Yes 2 No hours after death with the Maryland Biltimory Director 10g, Citizen of What Country? 10e. Street and Number or items 23a or Punte 9199 USA Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 14. Race - American Indian, Black, 12 Was Decedent Ever in U.S. 11 Marital Status must be If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. Armed Forces 1 Never Married Yes nore, MD 21215-0036
gas 1 and 2 should be filed within 72 hours after d
t of Health and Mental Hygiene.
t: If item 27 is marked other than "natural", or
other tranmatic event, the Medical Examiner. 1 Yes 2 No specify Widowed 4 Divorced If Yes, Give Year Specify. White à 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) onstruction 19 anstruction Worker 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Robert 19a Informant's Name/Relationship (Type, Print) 19b, Mailing Address (Street and Number or Rural Route Number City or Town, State, Zip Code) Town, State Buchit mphu mother Mary ane Apt. 102 -lenn. 20b. Place of Disposition (Name of cemetery 20a. Method of Disposition crematory or other place) or other 2 Cremation mportant Grema ton 7-27-06 Other Specify Funeral Service Lice 22. Name and Address of Facility 1232 Midvalley Dr. PA JUSSUP 18434 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interva **Physician** Between Onset and falure. List only one cause on each line /Medical Death a Gastrointestinal hemorrhage Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of) b Ruptured esophageal varix Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause Complications of chronic ethanolism (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) and Physician/Medical UNPENDED AMENDED burial ertificate be Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy 23d Date of delivery ending phys use as the b 23b. Was decedent pregnant in the past 12 months? Live birth 3 Ectopic pregnancy Month Day Year Fetal death Pregnant at time of death Other (Specify, 1 Yes 2 No 9 Unknown a Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I P.0. þ Yes 2 V No 3 Probably 4 Unknown Completed Records, 24a. Was ar 24b. Were autopsy findings available been autopsy prior to completion of cause of certificate has performed? death? 1 🗸 Yes Yes 2 No 26 Place of Death (Check only one 25. Was case referred to medica To the Hospital or Attending Physician: Division of Vital Be Other<sub>4</sub> Hospital: 1 2 ER/Outpatient 3 DOA Nursing Home 5 Residence 6 Inpatient Other this 1 V Yes After 27. Manner of Death 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: ✓ Natural Yes 2 No Pending hours after death. the Director: Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide To the Funeral (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie July 20, 2006 O.C.M.E anuk

DHMH 17 Rev 1/2001

**OCME 2006** 

State Registrar

111 Penn Street, Baltimore, MD 21201

30. Name and address of person who completed cause of death (Item 23a)

Pamela Southall, MD

31 Date filed (Month, Day, Year

Assistant Medical Examiner

DIVIVAILIO, ROSE Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1- For State Amend item#1,4a,perMD,g857,7/25/06 TTCertificate of Death Reg. No. 2 Date of Death 1. Decedent's Name (First, Middle, Last) ROSE DIVIRGILIO Day Month Physician 2006 :25 A M 8 **DiVIRGILIO** Jul /Medical 4a. Facility Name (If not institution, give street and number)

\*\*REWICK\*\* NURSING HOME 4c. County of Death 4b. City. Town, or Location of Death Examiner BALTIMORE N/A If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1□ M 2□ F 202-01-1299 89 Director 11/26/1916 PAUsual Residence of Decedent 10c. City, Town or Location 10d. In side City Limits 10a. State 10b County rthan "natural", or Iteme 23a or 28a-f show the Medical Examiner must be notified at MD N/A 1 ☐ Yes 2 🔀 No BALTIMORE Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 700 W. 40th STREET U.S.A. 21211 Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 and 2 should be filed within 72 hours efter 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No WHITE Specify: þ 3 ₩idowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 16a, Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) CLERK TYPIST PRINTING 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be **ABRAHAM SCHULTZ** DORA FELDMAN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DIANE DANIELS / NIECE 6709 LAURELWOOD AVENUE - BALTIMORE, MD 21209 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition Pages Inent of Hant: If ite 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) permit. Page Depentment Important: If eny injury or once. OHEB SHALOM MEMORIAL 07/20/2006 REISTERSTOWN, MD 21. Signature of Feneral Service Licensee 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 a 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, ophean failurg. List only one cause on each line. Approximate Interval Between Immediate Gause (Final disease or condition resulting in death) ementia **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events Due to (or as a consequence of) Examine ettending physicien and for use as the hunter resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23h. Was decedent pregnant 3 Ectopic pregnancy Year in the past 12 months? Month 5 Other (specify) signed by the e 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ SACYAL DecuBI 1 Yes 2 No 3 Probably 4 nknown should I Completed DISORDER 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? pege 2 s autopsy performed 1 ☐ Yes 2 ☐ No certificete 1 Yes 2 No To the Hospital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one, Hospital: 1 ☐ Inpatient Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA this 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No d in by the f 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number D3510Z Om mg 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Baltimore Fortiein Strut 700 WEST m.T. DON HILARY 32. Pegistrar's Signature State 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 0 0 5 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death George Everette Month Year **Physician** July 200de /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Mercy Medical Center Baltimore Il Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Quantry) **Funeral** 1 M 2 □ F Yrs. Director Usual Residence of Decedent 10d. Inside City Limits 10a. State 10c. City, Town or Location 10b. County 28a-f show permit. Pages 1 and 2 should be filed within 72 hours elter death with the Maryla Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or iteme 23a or 28a-f show eny hjury or other treumatic event, the Medical Examinar must be notified at once. 1 XYes 2 No Maryland 10e. Street and Number Funeral Director 10g. Citizen of What Country? 10f. Zip Code 2122 WOOd12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 Specify: Bla 1 ☐ Yes 2 No Specify: ģ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 18. Mother's Name (First, Middle, Maiden Sumame) 17 Father's Name (First, Middle, Last) Be 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) e Woodington 20b. Place of Disposition (Name of cemetery, crematory or other p Date 20a. Method of Disposition 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee Home ineral therethe disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Aspiration Preumonic **Physician** 3 Days /Medical Due to (or as a consequence of): **Examiner** Parkinson's Dementia Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of): signed by the attending physicien d be detached for use as the burial Completed by Physician/Medical 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 3 ☐ Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 3 ☐ Probably 4 ☐ Unknown 1 ☐ Yes 2 ☑ No should should WOSEDSIS 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed this certificete 1 Yes 2 No 1 🗌 Yes 2□ No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA within 24 hours after death.

To the Funeral Director: After thi
completely filled in by the funeral 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Mannef ol Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide to the Hospital 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number Stanti 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 2 707 South Lakewood Ave. Baltimare, MP 21224 Staits Francesca 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 5 2006 1 50 1 48 A Registrar

		4	State of Maryland / Depa	artment of Health and M	lental Hygien	711116	23224
			Decedent's Name (First, Middle, Last)		2. Date of Death Month Da		3. Time of Death
	Physicia /Medic		PETER EVERETT, JR.		JULY 21	2006	6:20 A M
/	Examin	er	4a. Facility Name (If not institution, give street and number)  5413 PEMBROKE AVENUE	4b. City, Town, or Location of Death  BALTIMORE CIT		: County of Death N/A	
	Francis		5. Social Security Number 6. Sex., 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.	9 Date of Righ	0 Riethal	ace (State or Foreign
Н	Funeral Director		241-40-7216 1 M 20F 79 Yrs.	Months Days Hours Min.	(Month, Day, Year	26 Count	IVC
	pud *		Usual Residence of Decedent           10a, State         10b, County         10c, City_Town or Lo	ocation		10	Od. Inside City Limits
	Maryla febo	To	MN N/A Ra	Hore			Yes 2□No
	r 28a-	Irec	10e. Street and Number	10f. Zip Code	10g. C	tizen of What Coun	try?
	23a o	Funeral Director	5413 rembroke AVE	21207		US.	1-1
	er dea Itema	nue	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces (1)	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - America Black, White,	
38	or, or	by	1 Never Married 2 Married 1 Yes 2 No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ Specify:		Specify:	ack
21215-0036	72 hou	Completed	15. Decedent's Education 16a. Deced (Specify only highest grade completed) (Give	dent's Usual Occupation kind of work done during most of work DO NOT use retired)	ing 16b.	(ind of Business/Inc	lustry
2	vithin ne. hen	mple	Flementary/Secondary (0-12)   College (1-40r 5+)	DO NOT use retired)	lacke (	PASTIVE	Two
	filed within 72 hours after death with the Maryland Hygiene. other then "neturel; or Itema 23a or 28a-f ehow ant, tre Medical Examiner must be notified at	ပ္ပိ	17_Father's Name (First, Middle, Last)		(First, Middle, Maide		, ,,,, ,
a	Aental Mental rkad c	To Be	Peter EvereTT Se	Della	a Ho	wer S	
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If Item 27 ie marked other than "neturel; or Itema 23a or 28a-f ehow eny Injury or other traumatic evant, Ite Medical Examinat must be multified at once.		11 -	ng Addrus (Street and Number or Rura		/ /	1 11/1
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Baltimore,	Pages nent of the int: If Its iry or of		1 □ Burial 2 ○ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	mator or other place	WAL B	VITO 1	VY)
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ä	Depa Impo eny I		> Torum R Howell & 4	600 LiBENTY 1	大人 E	HR MI	021207
			23a. Part . Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory arrest,		Approximate Interval Between Onset and Death
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		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying				
	acuted ind transit	Examiner	Cause (Disease or injury that initiated events c		<del>.</del>		
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687		edicai	d				
Box	death certifica e attending ph id for use as tl	W/W	IF FEMALE: 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 3 ☐	Ectopic pregnancy		23d. Date of delive	•
. B	e deat the att	Physician/Med		Other (specify)		Month	Day Year
P.O.	thet the	Phy	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did tobacco	use contribute to th	e cause of death?
ds,	taw requires thet the as been signed by th 2 should be detache	d by			1 🗆 Yes	No 3□ Prob	ably 4 ⊟Unknown
S	s beer 2 shou	Completed			24a. Was an autopsy	24b. Were autop	osy findings available inpletion of cause of
<u> </u>	Page 1	Com			performed?	death?	2□No
/ita	Physician: Tripis certificetral director, pi	Be	25. Was case referred to medical examiner?	Other	h (Check only one)		
<del>o</del>	Phys r this rai dir	To	1 Yes 2 No Panding 1 In Inpatient 2 ER/Outpatient  27. Manner of Death 28a. Date of Injury 28b. Time of Injury (Month, Day Year)	THE SEL BOX 4 INDISING THE	me 5 Residence 28d. Describe how inj		0
<u>o</u>	Attending in death.	atior	1 Natural 5 Pending (Month, Day Year) Injury 2 Accident investigation	Work? M 1 ☐ Yes 2 ☐ No			
Division of Vital Records,	or Attendate death Director:	Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, st building, etc. (Specify)	reet, factory, office	28f. Location (Street a City or Town, Sta		l Route Number,
Ω	pital o		29a. Certifier 1♥ Certifying Physician: To the best of my knowledge, deat	th occurred at the time, date and place	and due to the cause/	c) and manner as st	atad
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director; After this certific completely filled in by the funeral director.	edicai	(Check only one)  2 Medical Examiner: On the basis of examination and/or in and manner stated.				
	To the Hospital of within 24 hours at To the Funeral D completely filled in	₩.	29b. Signature and title of certifier	29c. License number		ate signed (Month,	
	1		Musda	DZ907	).	-14-0,	6
	4		30. Name and address of person who completed cause of death (Item 23a) (Type,	D 29 07 Print) J. EUTAW 57 (	1 21-11	1001	1 A 7 17 2 1
7	St	te	31. Date filed (Month, Day, Year) 32. Registrar's Signature		a MULIN	colle 10	20/10/
	Regist		JUL 2 5 2006 Januar J.	Sparke			

DHMH 17 Rev 1/2001

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene, 1 - State Registral Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE IGHION GARDENS PIKESVILLE If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 04/22/1924 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🗶 F Months 089-16-8261 82 Yrs **POLAND** Director Usual Residence of Decedent death with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits 28a-f show injury or other traumatic event, the Medical Examiner must be notified at Director 1 ☐ Yes 2 No MD BALTIMORE WOODSTOCK 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 2307 SIENA WAY 21163 USA 'natural', or items 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ሺ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: WHITE ģ Specify: 3 X Widowed 4 □ Divorced Be Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry filed within Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed wil Depertment of Health and Mental Hygient Important: if item 27 is marked other the eny injury or other traumatic event SECRETARY IMPORT-EXPORT COMPANY 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) BEN KIRSCHEN (UNKNOWN) BELLA 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) BRUCE EISEN / SON 2307 SIENA WAY - WOODSTOCK , MD 21163 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 🌣 Removal from State ETERNAL LIGHT CEMETERY 07/22/2006 BOYNTON BEACH, FL 4 □ Donation 5 □ Other (Specify) Funeral Service 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, on each line. Part1. Enter the disease shock, or heart failure. I Approximate Interval Between Onset and Death Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dua to for as a consequence of Examine -transit The law requires that the death certificate be executed Due to (or as a consequence of) use as the burialthe attending physicien Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?

1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy ō Month Day Year 4 Pregnant at time of death 5 Other (specify) be detached f 9 Unknown 9 Unknowl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy perform 1 Yes filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check on one 1 ☐ Yes 2 Hospital Other: 2 1 Inpatient 3 DOA 2 ER/Outpatient Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Ca To the Hospital or Attending Pi within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral 28b. Time of 28d. Describe how injury occurred Certification: After Injury 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Duicide Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) 29b. Signature and title of dertifier 29c. License number 30. Name and address person who completed cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) bgistrar's Signature State 2 5 2006 Registrar DHMH 17 Rev 1/2001

DHMH 17 Rev 1/2001

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Maryland / Department of Health and Mental Hygie

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more, MD 21215-0036 Pages I and 2 should be filed within 72 hours after death with the Maryland tent of Health and Mental Hygiene unt: If item 27 is marked other than "natural", or items 23a or 28a-f she or other tranmatic event, the Medical Examiner must be notified at once	Funeral	Never Married     Widowed	2 Married 4 X Divorced	Armed Forces  1 Yes 2	X No		s, specify $C$			Puerto R	ican, etc.)		White, etc.		
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State of Maryland / Department of Health and Mental Hygiene 1- State Registrar Amend #18 Per FH G857 7/25/OGe CHATCO of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician July 22, 2006 8:00 A M William Fandek /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Baltimore 8204 Burnley Road Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) B. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 X M 2 □ F Yrs. Director 1915 Wisconsin 283-14-6525 91 Usual Residence of Decedent 10b. Count 10d. Inside City Limits 10a. State 10c. City, Town or Location rthen "natural", or items 23s or 28s-f show the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Towson Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? USA 8204 Burnley Road 21204 filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Amed Forces?
1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Never Married 2 💢 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: δ 3 ☐ Widowed 4 ☐ Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) al Hygiene. College (1-4or 5+) Elementary/Secondary (0-12) Moore-McCormack Sea Captain 12 n/a With Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: if Item 27 is marked oth eny july or other treumatic event ORE: Be Wilhemina Fandek Marks Herman 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 8204 Burnley Road, Towson, MD 21204 Kari Fandek/Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State 4 Donation 5 Other (Specify) Metro Crematory 7/26/06 Catonsville, Maryland 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc.
10 W. Padonia Road, Timonium, Maryland 21093 W. Clary Bry n daused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, each line. Approximate Intervat Between Onset and Death 23a. Part1. Enter the disease, or complications that shock, it heart failure. List only one cause on tmmediate ause Final disease or condition resulting in death) Priysician /Medical consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine attending physician and I for use as the burial-transit The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequ Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 ☐ Ectopic pregnancy in the past 12 months? Month Year 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No be detached Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۾ 1 Mes 2 No 3 Probably 4 Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 Yes 2 No To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 ☐ Nursing Home 5 🖫 Residence 6 ☐ Other (Specify) 1 Tes 2 No 1 🗌 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 27. Manner of Death 28b. Time of Certification; 1 XNatural 5 Pending М 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be determined 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 T Homicide 29a. Certifier 1 X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signatur And title of pertiner 29d. Date signed (Month, Dey, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Albert M. Deloskéy, 515 Fairmount Ave., Suite 330, Towson, MD M.D. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar JUL 2 5 2006

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John Thomas Fie		- For State	Stat	e of Maryla		epartm Certific			id Men	tal Hyg		g. <b>N</b> o.	20	06 2322
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Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		21. Signature of Fi	uneral Service Li	censee	/ 1		lМа	ame and Addre	H We	st.				
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D lospital l hours uneral		4 Homicide 29a. Certifier	Certifying Phy	sician: To the be		House	eath occu	rred at the time	date and n					
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State of Maryland / Department of Health and Mental Hygiene 1 - State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Melvin 755 AM IRETER ,2006 July /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Stella MARIS Hospice BALTIMORE IMONIUM 1 Year Ift Under 24 Hrs. B. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday)
Yrs. 6. Sex Birthplace (State or Foreign Country) **Funeral** 216-10-7348 10 M 2 F Months MD. **Director** Usual Residence of Decedent deeth with the Maryland 10a. State 10b. County 10c. City, Town or Location in then "natural", or Itama 23a or 28e-f show the Medical Examiner must be notified at 10d. Inside City Limits 1 Yes 2 No MD BALTIMORE Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 939 RODMAN 21205 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 Mo If Yes, Give Year or Dates: 1 Never Married 2 Married 1 Yes 2 No Specify: Specify: WhiTe Completed by 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then " Elementary/Secondary (0-12) College (1-4or 5+) AWNINGS CORP. Installer 12th NA Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of 2 should be Inknown INKNOWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Pages 1 and 2
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nt: if item 27 is n.
y or other 939 RODMAN WAY BALTO MO 2120 JU60 Helen 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State permit. Page Department o Important: If any injury or once. BAYVIEW Crematory 4 □ Donation 5 □ Other (Specify) 22 Name and Address of Facility PAUL STEUR FUNERAL Home, PA.
1521 harford RD. BALTO NO 21034 21. Signature of Funeral Service Licensee taul m. 23a. Par 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shick, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** END STAGE DEMENTIA /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to for as a consequence of burial-transit C. Due to (or as a consequence of): Physician/Medicai for use as the IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day 4 Pregnant at time of death 5 Other (specify) ete hes been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Be Completed by Records, 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 2 No Vital 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) HOSPICE Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA 1 ☐ Yes 2 🗙 No Certification: To of this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 X Natural 5 Pending efter death. 1 ☐ Yes 2 ☐ No 2 Accident investigation the 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, elc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide within 24 hours e To the Funeral I Hospital Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medicai 29a. Certifier (Check only one) 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year) 32 Registrar's Signature State JUL 2 5 2006 Registrar

DHMH 17 Rev 1/2001

MELVIN FRETER

			For State Registrar	State of Ma	aryland		irtment tificate				R	eg. No.	006		323	
	Physici	an	Decedent's Name (First, Middle, La	•							Date of Deat Month UIY	th 20	2006		me of Dea	
	/Medic	al	Delia Cecelia Gi  4a. Facility Name (If not institution, giv				4h City To	OWD OF	Location of		uıy		Ounty of Dea		5 P.	IVI
	Examin	er	Blakehurst Care				Towson		Location	I Death			timor		nty	
	Funeral		5. Social Security Number 6. S	Sex Y 7. Age	e (In yrs. last	birthday)	If Under 1	Year Days	If Under 2	24 Hrs. 8. [	Date of Birth	Year)	9. Bi	rthplace (S	tate or Fo	reign
ı	Director			1 □ M 2 🗹 F	102	Yrs.	Months	Uay 3	riouis	Jai	Date of Birth (Month, Day, n. 29	190	4 Ma:	rylan	d	
	and w		Usual Residence of Decedent  10a. State 10b. County		10c. City, T	own or Lo	cation							10d. Ins	ide City Li	imits
	Mary -f eho	ģ	Maryland Baltim	ore County	Tows	on								10	Yes 2	X <sub>No</sub>
	h the	irec	10e. Street and Number				10f. Zip C	Code			1	0g. Citize	on of What C	ountry?		
	ath wi	ral	1055 West Joppa				2120						ed St			
ဖွ	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23s or 28s-f show any injury or other traumatic event, the Medical Examinar matches notified at ODGs.	/ Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  V	12. Was Decedent! Armed Forces? 1 ☐ Yes 2 ☑ I If Yes, Give			Vas Decede I Yes, specif		spanic Orig n, Mexican Specify:	gin? (Specify , Puerto Rica	Yes or No- in, etc.)		I. Race - Am Black, Wh Specify: W	ite, etc.	an,	
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212	d with	mo	Elementary/Secondary (0-12) 12	College (1-4or 5 N/A	<sup>+)</sup> I	Homem	aker					Own	Home			
Maryland	be file	Be	17. Father's Name (First, Middle, Last George Elback	")						r's Name <i>(Fil</i> Sa Elba		Maiden S	'umame)			
<u> </u>	hould d Mer marke marke	၉	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	a Address (	Street a		or or Rural Ro		r. City or	Town, State.	Zip Code)		
	nd 2 s lith an 27 le		Mr. William Gros	· - ·	1					e, Lutl					1286	
Baltimore,	of Heg of Heg Fitem rothe		20a. Method of Disposition 1 ☐ Burial 2 🗡 Cremation 3 €	Demousi from State	cem	eterv. crer.	sition (Name	ner placi	θ) -	1/ Date			ation - City o			
Ĕ	Pag tment tant: I		4 ☐ Donation 5 ☐ Other (Speci	fy)	Evai		neral			1241			t Hil			
Ball	Deperting Deperting Important Import		21. Signature of Funeral Service Lice	le Aum		Pe 23	Name and acefu. 25 Yo	Addres 1 Al rk F	is of Facility Lterna Road,	atives Timon	Funer	al&C aryla	rematind, 2	ion C 1093	tr.	P.A.
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	nplications that caused one cause on each lin	the death.	Do not ent	er the n ode	of dying	g, such as	cardiac or re	spiratory arr	est,		Interv	ximate al Betwee and Dear	
	Pnysician /Medical		Immediate Cause (Final disease or condition resulting in death)	a alls	recon		Du	en	ec_						cara	
я	Examiner			Due to (As	a consequer	nce of):								0		
		ē	Sequentially list conditions. If any, leading to immediate cause. Enter Underlying	b. Due to (or as	a consequen	ice ol).								-		
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687	ficate physis the			d									-		4	
Box (	death certifica e attending ph d for use as th	N/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth			Tetania asa					23	d. Date of de	elivery		
.O.		by Physician/Med	in the past 12 months2 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at 9☐Unknown			Ectopic pred Other <i>(spe</i>						Month	Day	Year —	ŕ
s, P	The law requires that the site hes been signed by the bage 2 should be detache	y Pt	Part II. Other significant conditions	contributing to death b	ut not resultir	ng in the u	nderlying cau	use give	en in Part I.		23e. Did tol	bacco use	e contribute	to the caus	e of deatl	h?
ğ	w requires to been signer should be		Morne cope	rollin	10 0						1 🗆 Y	es 2 🗆	No 3∏F	robably	4 Onkr	าอพก
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ŏ	Phys ar this aral di	J: To	1 Yes 2 Ho 27. Manner of Death	28a. Date of Inju	nt 2□ER	b. Time o		c. Injury		rsing Home 28d.	Describe h			өсігу)		
Ö	ath. r: Afte	ation	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		y Year)	Injury	М		<7 Yes 2 □ l	No						
Division	or Atte	Certification:	3 Suicide 6 Could not l 4 Homicide determined		ury - At home c. (Specify)	e, farm, str	eet, factory,	office		28f.	Location (Si City or Town		Number or F	Rural Route	Number	,
۵	To the Hospital or Attending Phys within 24 hours elfer death. To the Funeral Director: After this completely filled in by the funeral di	edicai Ce	(Check only 2 Medical Exe	hysician: To the best											use(s)	
	thin 2 the 1 the 1	Med	one) 29b. Signature and title of certifier	and manner sta					e number				signed (Mor	1		
	F F B		)/M -	Max			1	1	887	12-	_   "	7	121	121		
	2		30. Name and address of person who	completed cause of o	eath (Item 2	3a) (Type,	Print	00	002	1_1	, 1		1		,	
	)		K. Haberso	it 111	MIC	arn	wh Ke	d	Tari	blen,	MI	) 2	114	0_		
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registr	ar's Signatur	e A	had!									
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ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 2 [ ] [ 1 - For State Registra Certificate of Death 2. Date of Death 1 Decedent's Name (First Middle Last) 3. Time of Death **Physician** MARTHA CHATES 06.52 AM 2006 0 -15 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death **Examiner** General Hosp Howard County Howard Culumbia If Under 1 Year | If Under 24 Hrs. | 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Dec 31, 5. Social Security Number Birthplece (State or Foreign Country) **Funeral** Days Hours 1 ☐ M 2 K F Yrs 1942 63 Virginia Director 225-54-9649 Usual Residence of Decedent with the Maryland 10d Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or iteme 23a or 28a-f ehow empiriquery or other treumatic event, the Madical Examiner must be notified at once. 1 X Yes 2 ☐ No Director Roanoke VA 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 24017 2719 Tremont Drive USA 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 X Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify. 2 3 ☐ Widowed 4 ☐ Divorced **Black** Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a, Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 NIA Rehab Center Dietician 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be 2 Charles Cornelius Gates Sr. Willie Mae Bouldin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1473 Potomac Heights Dr., Ft. Washington, MD 20744 George B. Gates Sr. -Brother 20c. Location - City or Town, State 20b. Place of Disposition (Name of Date 20a. Method of Disposition cemetery, crematory or other place 1 Burial 2 Cremation 3 Removal from State MeMorial Park 4 ☐ Donation / 5 ☐ Other (Specify) 07-20-2006 Roanoke, Virginia 21. Signature Ameral Selvice Vicen 22. Name and Address of Facility 23a. Party. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or pear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pyram Cram negative
Due to (or as a consequence of): Septic **Physician** /Medical Examiner Secus tizily list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) ettending physicien for use as the buria Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year Day 4 Pregnant at time of death 5 Other (specify) P.O. tor: After this certificate has been signed by the the funeral director, page 2 should be detached 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performe 20 No 1 ☐ Yes 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatienl 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury al Work? 28d. Describe how injury occurred Division 1 Natural 5 Pending investigation after death. Director: Af 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide 24 hours a 1 Cartifying Physician: To the best of my knowledge death incurred at the time, date and place and the time, date and place, and due to the cause(s) and mariner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical To the Hoep within 24 hor To the Fune completely fi (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D0053719

Registrar DHMH 17 Rev 1/2001 KAT

31. Date filed (Month, Day, Year)

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Fox lane

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30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

14300

32 Registrar's Signature

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2 5 2006

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Bowie

MD 20715

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** July 24, 2006 8:30A M Gi11 Melvin Raymond /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Baltimore Towson Brighton Gardens of Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□ F Months Days Hours Yrs. Sept 4, 1921 Maryland 213-14-0729 84 Director Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10a. State 10b. County 10c. City. Town or Location rei', or iteme 23a or 28a-f ehor Examiner must be notified at 1 ☐ Yes 2 X No Maryland Baltimore Towson Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21204 USA 7919 Roldrew Avenue Funerai filed within 72 hours after death 14. Race - American Indian. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ▼ No Specify: ģ 3 ₩Widowed 4 Divorced White "naturel" in Medical Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Trucking 11 n/a other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be is marked of Pages 1 and 2 should be Rae Carver G111 Esther 2 Raymond Frank 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 a Department of Health ar Important; if item 27 is eny injury or other treu 7919 Roldrew Avenue, Towson, MD Donna G. Breuning/Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Pikesville, Maryland 7/26/06 Druid Ridge Cemetery 2) Signature of Jungal Service Liversco 22. Name and Address of Facility
Lemmon Funeral Home of Dulaney Valley Inc. Bryan W. Clary 10 W. Padonia Road, Timonium, MD 21093 23a. Part1. Finter the disease, or complications that haused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock or heart failure. List only one cause on lach line. Immediate ause rinal disease or condition resulting in death) LVNG months Physician Cancer /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit Attending Physicien: The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of) Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 ☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Yes 2 No 3 Probably 4 Unknown 24a. Was an autopsy performed? 1 ☐ Yes ②☑ No 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No certificate Be 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Mother (Specify) ASSIFTED LIVI ဥ 1 Yes 2 No this After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: 5 Pending 1 Natural 1 Tyes 2 No death. naral Director: A filled in by the ft investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 6 To the Hospitel within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) JULY 24 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) have St Browns un 21204 Amon CHAMES. 31. Date filed (Month, Day, Year) 32 Registrar's Signature State 5 2006 Registrar

		•	•	State of Maryland /	Depa		t of H	ealth a		ental Hyg		_	23233
			1. Decedent's Name (First, Middle, Last)							<ol><li>Date of Dea Month</li></ol>	th Day	Year	3. Time of Death
	Physici /Medic		Evelyn M. G	raves						500	19	2006	9:00 PM
)	Examin		4a. Facility Name (If not institution, give st	reet and number)		4b. City,	Town, or	Location of	Death		4c. Co	ounty of Deat	
			Sinai Hospital of	Baltimore		Bal	time	ore C	itu			N/	A
	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. last t	birthday)	ff Under Months	1 Year	If Under 2 Hours	4 Hrs. Min.	8. Date of Birth Month, Day JULY 10	Year)	9. Birt	hplace (State or Foreign
	Director		214-56-5739	M 2⊠F 57	Yrs.					JULY 19	1949	9	MD
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36	rs aft	by F	1 X Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 🗆 Yes	2 <b>X</b> No	Specify:			S	pe <i>city:</i> F	3lack
21215-0036	within 72 hours after deeth with the Maryland ane. then "neturel", or iteme 23e or 28e-f ehow he Madical Examiner must be multisut at	edt	15. Decedent's Educ		a. Dece	dent's Usu	al Occup	ation			16b. Kind	of Business/	
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lan	id be ental ked o	ToB	William Grave	es				Mat	tie	Lawre	ence		
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Baltimore,	permit. Peges 1 and 2 Department of Health a Importent: if item 27 is eny injury or other tre		20a. Method of Disposition	20b. Place ceme	of Dispo	sition (Name	me of other place	e)	D	ate	20c. Loca	tion - City or	Town, State
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68	death certifica e ettending ph id for use as th	Physician/Med	IF FEMALE:										
Вох	th ce lendi	an/	23b. Was decedent pregnant	lc. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea	ath 3[	⊒Ectopic p	regnancy				23	d. Date of del	livery Day Year
	dea he et ed fo	sici	in the past 12 months? 1 ☐ Yes 2 ☑ No	4☐Pregnant at time of death 9☐Unknown	5[	Other (se	pecify) _	-				WOTE	Day Tour
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	requires that een signed b hould be deta	þ	Part II. Other significant conditions con	inbuting to death but not resulting	g in the u	inderlying (	cause giv	en in Paπ I.				No 3 ☐ Pi	the cause of death?
brd	equir sen s ould	ted									<b>e</b> s 2	NO 3   F	ODADIY 4 EJOHKHOWII
Ö	as be	Completed								24a. Was autop	sy	prior to	utopsy findings available completion of cause of
<b>E</b>	sician: The law certificete has t irector, page 2 s	Į,								perfor	rmed? 2 Vi No	death? 1 ☐ Yes	2 2 No
ita'	ctor,	Be (	25. Was case referred to medical examiner?						of Death	(Check only o	ne)		
7	hysic his co	ို	1 ☐ Yes 2 ☑ No	ospital: 1 ☑Inpatient 2 ☐ ER/	-			4 🗆 140		ne 5 🗆 Resid			icify)
u u	ng P fter t		27. Manner of Death 1 Natural 5 □ Pending	28a. Date of Injury 28t (Month, Day Year)	o. Time o Injury		28c. Injur Wor	k?		8d. Describe h	iow infury	occurred	
sio	eath. or: A	cati	2 Accident investigation 3 Suicide 6 □ Could not be			М		Yes 2 1					
Division of Vital Records,	or Ati	E	4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, tarm, st	reet, factor	y, office		1	City or Tow		Number or Hi	ural Route Number,
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical Certification;	00- 0-44-4		fac d	16			d el-				
	Hoep 4 ho Fune tely fi	Ca	(Check only 2 Medical Examin	ician: To the best of my knowled er: On the basis of examination									
	the the mplet	Med	one) 29b. Signature and title of certifier	and manner stated.		29	c. Licens	e number			29d. Date	signed (Mont	th, Day, Year)
	T v v		255. Signature and title of Certifier										
	1		chen Har		\_	<u> </u>	R	25-00	0		Ja	14 19	,2006
	1		30. Name and address of person who co	mpleted cause of death (Item 23	a) (Type	Print)	/	( > 1					
			Irene Hao  31. Date filed (Month, Day, Year)	32. Registrar's Signature	gi	madi	tal o	ES-00 f Balti	more				
	Regist	ate	31. Date fifed (Month, Day, Year)	32. Registrar's Signature	19								

DHMH 17 Rev 1/2001

Patient known as Evelyn Marie Graves.

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar 23234 Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 19, 8:30 A M Lavore Goughenour July 2006 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 448 River Road Arnold Anne Arundel Il Under 1 Year | If Under 24 Hrs. | Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, **Funeral** Days 1□M 2XF Hours βA 190-26-4859 72 June 10,1934 Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "natural", or Items 23a or 28a-f show It e Medical Examinar must be notified at 1 ☐ Yes 2X No Anne Arundel Arunde1 Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 448 River Road 21012 U.S.A. Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black White etc 1 ☐ Yes 2 XNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No White ģ Specify: 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Clerk State of Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If item 27 is marked oth any link or other traumatic event once. Guy L. Miller Anna Ora 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Son Mr. Frederick A. Goughenour Jr. 448 River Road Arnold, Maryland 21012 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, Slate July 24, IX Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Maryland Vet. Cem. 2006 Crownsville, MD 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Singleton Funeral Home, P.A. M01479 1 Second Avenue SW Glen Burnie MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Onset and Death Immediate Cause (Final disease or condition resulting in death) MYOCARDIAL INFARCTION

Due to (or as a consequence of): **Physician** /Medical Examiner HPART DISEASE SCHEMIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Diseese or injury that initiated events resulting in death) Last Due to (or as a consequence of) attending physician and for use as the burial-transit Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Pes 2 No
9 Unknown 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the at d be detached for 9 Unknown Part II. Other significant conditions contributing to death bull not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 Probably 4 Whknown 24b. Were autopsy lindings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an autopsy performed? 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 | Inpatient 2 | ER/Outpatient 3 | DOA Other: 4 Nursing Home Residence 6 Other (Specify) 1 Yes 2 No ို 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time ol Injury 28d. Describe how injury occurred Certification: Natural 2 Accident 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 3 ☐ Suicide 6 Could not be Place ol Injury - At home, larm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Momicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier Thomas haldeno 123867 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 277 PEDINSHIA FARM RUAD ARNOLD, MD THOMAS WALSH MD 32. Resistrar's Signature 31. Date filed (Month, Day, Year) State Registrar

		-	For State Registrar	State of Maryland	-	artment of Hertificate of L			giene Reg. No	106	23235
			Decedent's Name (First, Middle, L	ast)				2. Date of De Month	ath Day	Year	3. Time of Death
	Physicia Medic		Louis	GOODMAN				JULY	19	2006	12:48 PM
	Examin		4a. Facility Name (If not institution, g	ve street and number)		4b. City, Town, or	Location of I	Death		inty of Death	
			VIII	SPITAL		ELICT	DN If Under 24	I Ura		Jec 11	
	uneral		5. Social Security Number 6. 218-09-4935	Sex 7. Age (In yrs. I.	ast birthday) Yrs.	If Under 1 Year Months Days		Min. (Month, Da	y, Year)	Coun	
	irector	-	Usual Residence of Decedent	85				Aug. 12	2,1920	Mary	land
yland	Mon Te	Ì	10a. State 10b. County	10c. City	, Town or Lo	ocation				11	Od. Inside City Limits
Маг	a-f st	ctor	Maryland Ce	cil		Cole	ora				1 ☐ Yes 2½ No
it th	or 28	Director	10e. Street and Number			10f. Zip Code			-	of What Coun	•
ath w	1 238 ust t	ra E	15 North Fri				21917			ed Sta	
er de	Itams nat n	nue	<ul><li>11. Marital Status</li><li>1 ☐ Never Married</li><li>2 ☐ Married</li></ul>	12. Was Decedent Ever in U.S Armed Forces?	S. 13.	Was Decedent of His If Yes, specify Cubar	spanic Origii n, Mexican, I	n? (Specify Yes or No Puerto Rican, etc.)	14.1	Race - Americ Black, White,	
)36 rs aft	P. or	by Funeral	3 Widowed 4 Divorced	1 □XYes 2 □ No If Yes, Give Year or Dates: WW∐]		1 ☐ Yes 2 ☐ XNo	Specify:		Spe	ecify:	White
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	d oth evan	Be	17. Father's Name (First, Middle, La					s Name (First, Middle			
<b>S</b> bluot	i and Mental r Is marked of raumatic eva	ပ္	Jacob Morris (		10h Maili	no Address (Street a		na Virgini or Rural Route Numb			Code)
Mal d 2 st	T Is r		The state of the s	(Daughter)				Abingdon,			009
<b>6</b> ,	or Habits and Medical Hygeline in Tratural', or Itams 23a or 28a-f show itam 27 is marked other than "natural", or Itams 25a or 28a-f show other traumatic event. Its Medical Examinar must be notified at		20a. Method of Disposition	20b. P	lace of Disp	osition (Name of matory or other place	al I	Date	20c. Locati	on - City or To	wn, State
TOO	ant of ht: If i	1	1 ☑ Burial 2 ☐ Cremation 3  4 ☐ Denation 5 ☑ Other (Special Control C	Hemoval from State		n Cemeter		7/24/2006	Balt	imore,	Maryland
Baltimore,	Department of Health a Important: If item 27 Is any injury or other trainonce.		21. Signature of Fun ral Service Lic		2	2. Name and Addres	s of Facility	al Home of	Dunda	1½ Tne	~
m a	Important any ir		Und"	, rul				Dundalk,			222
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that causes the death ty one cause on eachdine.	n. Do not en	ter the mode of dying	g, such as ca	ardiac or respiratory a	rrest,		Approximate Interval Between
Pro	ysician	8 9	Immediate Cause (Final disease or condition	. END STA	CE	MYELDDY	ISPLAS	TIC SYN	DROM	IE	Onset and Death
	Medical aminer		resulting in death)	Due to (or as a consequ	uence of):	-		***			
	annine.	<u></u>	Sequentially list conditions,	b. Due to (or as a consequ		Lyre					
D. pg	nsit	Examine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	· CONVESTI	_	HEARY	FO	Just			
), execu	n and ial-tra	Exai	that initiated events resulting in death) Last	Due to (or as a consequ		LICITI		10000			
8760, V	ohysician and the burial-transit	dical		d							
	as th	Aedi	IF FEMALE:								
Box 6	attending p	an/l	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Fetal	I death 3	⊒Ectopic pregnancy			23d.	Date of delive Month	ry Day Year
D. Else des	the at had fo	Physician/Me	1 Yes 2 No	4∏Pregnant at time of de 9∐Unknown	eath 5	Other (specify)					
ords, P.O	ed by the detachad	Ph	Part II. Other significant conditions	s contributing to death but not res	ulting in the i	underlying cause give	en in Part I.	23e. Did	obacco use	contribute to th	ne cause of death?
ds,	signed h	d by						1 🗆	Yes 2 N	o 3 Prob	ably 4 □Unknown
ecor taw req	should	ompleted						24a. Was		4b. Were auto	psy findings available
Re ta	ate has page 2	шо						— auto perfo	psy ormed? 2 No	prior to con death? 1  Yes	npletion of cause of
ital Bn:	certificate irector, pag	O	25. Was case referred to medical				26. Place	of Death (Check only			
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Division	after death   Diractor: / d in by the f	Certification:	4 Homicide determin		y)	reet, factory, office			wn, State)	umber or Hura	l Route Number,
Hospital	24 hours a Funeral I etely filled		29a. Certifier 1 Certifying	Physician: To the best of my kno	wledge, dea	th occurred at the tim	ne, date and	place, and due to the	cause(s) and	d manner as si	ated.
e Hos	within 24 hours after of To the Funeral Direct completely filled in by	edical		caminer: On the basis of examina and manner stated.							
To the	within 2 To the Complet	Me	29b. Signature and title of certifier			29c. License	e number		29d. Date si	gned (Month,	Day, Year)
			MARIN	10		D00 U	46=	10	JULY	19	2006.
, (	14		30. Name and address of person wi	no completed cause of death (Item	n 23a) (Type	, Print)				,	
U	0		M. PRAT- UsunA	MA 106 50L	STO	SLKTO	N M	0 2192	1		
	Sta Regist	ate rar	31. Date filed (Month, Day, Year)	D6 32. Registrar's Sign	A STATE OF THE STA						

		-	For State		State of Ma	arylan			nt of Heal			giene Rog. No	2006	23:	236
			1. Decedent's Name (First, Mid	_							2. Date of De Month	_	/ I- Year	3. Time	of Death
	Physicia /Medic		Alva	10	don			45 035	Town and an	tion of Dooth	1 7	-	County of Deat		PM
	Examin	er	4a. Facility Name (If not institute 4355 Chap)	on, give st	reet and number)			Par Par	Town, or Loca and a 1/5 4	tion of Death	1	7	Baltimi		
	Funeral		5. Social Security Number N	6. Sex	M 200 F 7. Ag	e (In yrs. I	last birthday)	If Unde Months		nder 24 Hrs.	8. Date of Bir	th y, Year)	9. Birt	nplace (State untry)	or Foreign
	Director		Usual Residence of Decedent	''	M 200F	87	Yrs.	,			Hugust	19,1	918 Jan	MORE C	<u></u>
	yland how		10a. State 10b. Coun	У		10c. City	y, Town or Lo	cation						10d. Inside (	1 4
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	ems 2	Funeral Director	11. Marital Status	1	2. Was Decedent Armed Forces?		S. 13. \	Nas Dece	dent of Hispan	ic Origin? (Specifican, Puert	pecify Yes or No o Rican, etc.)		14. Race - Ame Black, White	rican Indian,	
36	rs afte	oy Fu	1 ☐ Never Married 2 ☐ Mi Widowed 4 ☐ Divorce		1 ☐ Yes 2 If Yes, Give Year or Dates:	ИО		1 ☐ Yes	200 Sp	ecify:			Specify: 3/	ack	
21215-0036	be filed within 72 hours after death with the Maryland ital Hygiene. id other then "natural", or items 23s or 28s-( show event, the Madical Exeminat must be nutified at	Completed by	15. Deced	ent's Educ	ation		16a. Deced	ient's Usu	ual Occupation ork done during	most of wor	kina	16b. Ki	ind of Business/	Industry	
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Q 0	Hygie other ent, IL	0	17. Father's Name (First, Middle	ə, Last)			/ "		18.	Mother's Nan	ne (First, Middle	, Maiden	Surfame)	CUIL CV	
/lan	should be ind Mental i marked umatic ev	To B	Edgar Mo	7+1-h	ews					/		ans			
Maryland	d 2 sho th and 7 is m traum		19a. Informant's Name/Relatio	iship (Typ	oe, Print)		19b. Mailir	ng Addres	s (Street and I	lumber or Ru	ral Route Numb		town, State, 2		91133
	s 1 and if Health item 27 other tr		20a. Method of Disposition	_/_ <i>_</i>	07.	20b. P	lace of Dispo emetery, crer	sition (Na	ame of other place)	1	Date		ocation - City or		
<u>=</u>	Pages ment of ant: If it ury or o		1 Burial 2 Crematio 4 Donation 5 Other		emoval from State	10	enmou	ntal	ematery	7/2	1106	Bai	Himorc.	MO	
Baltimore,	permit. Pages 1 and 2 should be fited within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or items 23a or 28a-1 show amy injury or other traumatic event, the Madical Examinat must be nutified at anone.		21. Signature of Funeral Service	e License	е 🕏		22	Name a	Ind Address of	Pacility P	eughn C	Grea	a MID	2112	22
			23a. Part1. Enter the disease,	or complic	cations that cause	d the death	h. Do not ent	er the mo	de of dying, su	ch as cardiad	or respiratory a	rrest,		Approxima Interval Be	ate etween
	Physician		shock, or heart failure. L Immediate Cause (Final disease or condition	st only on	A	SC	UD							Onset and	
	/Medical Examiner		resulting in death)		Due to (or as	a conseq	uence of):								
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9	rtificate ng phy: as the		IE EENALE.	-											
Вох	death certifica e ettending ph ed for use as th	lan/N	IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23	3c. If yes, outcome 1☐Live birth	2 Feta	Ideath 3[		pregnancy				23d. Date of dei Month	ivery Day	Year
P.O.		Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown		4□Pregnant a 9□Unknown	t time of a	eath 5	Other (s	рөспу)						
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ord	w requir been si should		demen	-tia								Yes 2			∃tinknown
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ita	icien: Th certificete rector, pag	BeC	25. Was case referred to med examiner?	cal					26.	Place of Dea	1 ☐ Yes ath (Check only	2[ <b>] N</b> 6 one)	1 10163	20110	
of <	th.  After this certifice tuneral director, p	ပို	1 ☐ Yes 2 ☑ No 27. Manner of Death	Н	ospital: 1  Inpati		ER/Outpatier			☐ Nursing F	lome 5 Describe			cify)	
ion	Attending or death. ector: Alter by the funer	ation	1 ☑ Natural 5 ☐ Pen	ding stigation	28a. Date of Inj (Month, Da	y Year)	Injury	м	28c. Injury at Work? 1 ☐ Yes	2 🗆 No	200. 0000.00		.,		
Division of Vital	or Attendi after death. Director: A in by the fu	Certification:		ld not be imined	28e. Place of In building, e	jury - At he tc. (Specif	ome, farm, str	reet, facto	ry, office		28f. Location ( City or To		nd Number or Re	ıral Route Nu	mber,
_	To the Hospital or Attend within 24 hours after death To the Funeral Director: completely filled in by the	ledical C			sician: To the best ner: On the basis of and manner s	of examina									(s)
	To the within 2 To the comple	Me	29b. Signature and title of cert	fier		/	,		9c. License nu				te signed (Mont	h, Day, Year)	
	n		1 Step	hu	- ) cum	sel.	mo		028	304		4/	20/06	2	
	,4		30. Name and address of pers	on who co	mpleted cause of		n 23a) (Type, Reis	Print)	-stow	n N	1021	13	6		
	St Regist	ate rar	31. Date filed (Month, Day, Ye JUL 2	<sup>ar)</sup> 5 200	32. Regist		sture A	and!	,						

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			1- State Amend PI, 25, perME, goos, 61/13/07	Department of Health and Me Certificate of Death	ntal Hygiene Reg. No. 2006 23238
			1. Decedent's Name (First, Middle, Last)		Date of Death Month, Day Year  3. Time of Death
	Physici: /Medic		David A.	Hutto =	July 20 2006 2028 M
	Examin	_	4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
			The Johns Hop Kins Hospi	thday If Under 1 Year If Under 24 Hrs. 8	/fy N/A
	Funeral Director		5. Social Security Number 212-82-7041 6. Sex 7 7. Age (In yrs. ) st bi	Months Days Hours Min.	Date of Sirth (Month, Day, Year) OCT 8, 1964  9. Birthplace (State or Foreign Country) MD
	_	-	Usual Residence of Decedent		OCI 0, 1904   FID
	yland	. [	10a. State 10b. County 10c. City, Tow	n or Location	10d. Inside City Limits
	e Mar	Ş	MD Baltimore Essex		1 ☐ Yes 2√2 No
	ih th or 28	Director	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	s 23a		5 Brett Ct. #112	21221	USA v Yes or No- 14. Race - American Indian,
10	s 1 and 2 should be filed within 72 hours after deeth with the Maryland I Heelih and Mentai Hygiene. Item 27 ie marked other than "neturel", or Items 23a or 28a-f show other treumatic event, its Medical Examinat must be notified at	Funeral	11. Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No	13. Was Decedent of Hispanic Origin? (Specifif Yes, specify Cuban, Mexican, Puerto Ric	źan, etc.) Black, White, etc.
5-0036	urs a	þ	3 ☐ Widowed 4 ☐ Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 X No Specify:	Specify: White
5-0	72 hc	Completed	15. Decedent's Education 16a (Specify only highest grade completed)	Decedent's Usual Occupation     (Give kind of work done during most of working)	16b. Kind of Business/Industry
2121	hen hen	ldm	Elementary/Secondary (0-12) College (1-4or 5+)	life. DO NOT use retired)	Di ==1.1 - 1
N	Hygie Hygie other t		17. Father's Name (First, Middle, Last)	Disabled  18 Mother's Name (F	Disabled First, Middle, Maiden Surname)
Maryland	2 should be filed v and Mental Hygie I e marked other t reumatic event, IL	o Be	Unknown	Unknown	
Z	should nd Men marke	ပ္		b. Mailing Address (Street and Number or Rural F	Route Number, City or Town, State, Zip Code)
	nd 2 sith a 27 le		Charles L. Hutto/ Foster Father	12 Cape May Place Berl	in, MD 21811
ē	es 1 a of Hee f Item r othe		20a. Method of Disposition 20b. Place of Comments	of Disposition (Name of Date of Page 1977), crematory or other place)	
Ë	Pages nent of int: If It		1 Burial 2 XCremation 3 Hemoval from State	Crematory, Inc. 7/24/	06 Baltimore, MD
Baltimore,	permit. Page Dapartment i Important: If eny Injury or once.		21. Signature of Funeral Service Licensee C. Todd Dring	Cremation Society of	Maryland, Inc.
<u> </u>	89629	- 13	i tall of	299 Frederick Rd Bal	timore, MD 21228
			23a. Part1. Enter the disease, or complications that caused the death. Do shock, or heart failure. List only one earlier on each line.	not enter the mode of dying, such as cardiac or r	espiratory arrest, Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition resulting in death)		30 Days
1	/Medical Examiner		Due to (or as a consequence	of):	$((a \lambda))$
		_a	if any, leading to immediate cause. Enter Underlying	Lof):	70 2475
	ansit	Examiner	cause. Enter Undertying Cause (Disease or injury that intiated events	surger h	50 page
oʻ	exec en an		resulting in death) Last	of):	MEDICALES
8760,	Physician: The law requires thet the death certificate be executed this certificate has been signed by the attanding physicien and rail director, page 2 should be detached for use as the buriat-transit	dlcal	d	OFFITE CATION APPROVED B	A Mine
9	artifice ing pl	Med	IF FEMALE:	CERTIFICATION	
Box	death certifice attanding ph	lan/	23b. Was decedent pregnant  23c. If yes, outcome of pregnancy  1 Live birth 2 Fetal deat	h 3 Ectopic pregnancy	23d. Date of delivery  Month Day Year
-	uires thet the de signed by the a Id be detached t	Physiclan/Me	1   Yes 2   No 9   Unknown	5 Other (specify)	
P.0	thet t ed by detac		Partil. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
ds	uires 1 sign 11d be	Completed by	Spinal BiEida		1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown
20	s been si should	Sete			24a. Was an 24b. Were autopsy findings available
Re	The la	E			autopsy prior to completion of cause of penformed? death?  1 ☐ Yes 2 ☑ No 1 ☐ Yes 2 ☑ No
ita	ian: rtifica	BeC	25. Was case referred to medical	26. Place of Death (0	
<b>\_</b>	hysic nis ce I direc	Tof	examiner?  1 X Yes Hospital: 1 Inpatient 2 ER/O	utpatient 3 DOA Other: 4 Nursing Home	5 ☐ Residence 6 ☐ Other (Specify)
D C	ng P		27. Manner of Death 28a. Date of Injury 28b. (Month, Day Year)	Injury Work?	d. Describe how injury occurred
sio	Attending r death. ector: After by the fune	cati	2 Accident investigation 3 Suicide 6 Could not be 288 Place of Injury - At home to	M 1 Yes 2 No	Location (Street and Number or Rural Route Number.
Division of Vital Records,	or Al aftar d Direc in by	Certification:	4 Homicide determined 28e. Place of Injury - At home, 1 building, etc. (Specify)	arm, street, factory, office	City or Town, State)
]	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier Certifying Physician: To the best of my knowledge	ge, death occurred at the time, date and place, and	d due to the cause(s) and manner as stated.
	Me Ho:	Medical	(Check only   Medical Examiner: On the basis of examination a one)	nd/or investigation, in my opinion, death occurred	at the time, date and place, and due to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d. Date signed (Month, Day, Year)
	/		DAIN MD	RES-000	JULY, 20, 2006
-	6		30. Name and address of person who completed cause of death (Item 23a)		BALTIMORE
			SHAMIL JAIN, MO THE JOHNS HOPK	INS HOSPITAL, GOO NORTH	WOLFE STREET, MARYLAND 21287
9	Sta Regist		31. Date filed (Month, Day, Year)  31. Registrar's Signature 32. Registrar's Signature	Goode	
	negist	ul	A COLUMN TO THE STATE OF THE ST		

									nd Mental Hy		gible.	
			For State	State of Ivia	Tylariu		tificate of		na mentai riy	2	006	23239
			Registrar  1. Decedent's Name (First, Middle, La	atl		Cer	illicate of	Dealli	2. Date of De	Reg. No.	000	2 Time of Booth
	Physicia	an		Denni	6	IN U	VIRCI		Month	Day	Year	3. Time of Death
	/Medic		michael		,	/ 1 0			501	24	2006	327J M
	Examin	er	4a. Facility Name (If not institution, giv	1			4b. City, Town, o				unty of Death	
			13821 Lore		//- · · · ·		Rock If Under 1 Year	If Under 2		me		merry
	Funeral		5. Social Security Number 6. S	7. Age	(In yrs. las	t birthday) Yrs.	Months Days	Hours	Min. (Month, D.	ay, Yea <i>r)</i>	Coun	
	Director	-	578-64-5917 Usual Residence of Decedent	X -	59_	713.			DEC 10	<u>, 1946</u>	Ohio	)
	pue *	1	10a, State 10b. County		10c. City, 1	Town or Lo	cation				1	Od. Inside City Limits
	lanyl eho	5	M 1 1 M 1				Dool	:11-				1 ☐ Yes 2 ☑ No
	28a-1	ect	Maryland Monts  10e. Street and Number	gomery			10f. Zip Code	ville		100 Citizan	of What Coun	
	with or	吉		_				853		rog. Citizer	USA	uy?
	be filed within 72 hours after death with the Maryland ital Hygiene.  did thygiene.  dother than "natural", or items 23a or 28a-f ehow event, the Madical Exat.: diet mat te notified at event, the Madical Exat.: diet mat te notified at	Funeral Director	13821 Loree Land	12. Was Decedent E		10.1			-2 (C*- V N	114	Race - Americ	an Indian
	er de	Š	11. Marital Status  1 □ Never Married 2 ☒ Married	Armed Forces?		13.1	Yes, specify Cub	an, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	14.	Black, White,	
2	rs aft	by	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:			I□Yes 2∑ No	Specify:		Sp	ecity: W	hite
3	hou ture		15. Decedent's E		1 ,	162 Decer	lent's Usual Occur	nation		16h Kind	of Business/Inc	
2	n 72	Completed	(Specify only highest gr		'	(Give	kind of work done OO NOT use retire	during most of	of working	TOD. KING	OI DUSINGSS/IN	ustry
7	withi ene.	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5-				,	iolia+		omputor	-0
2	Hygi ther int, t		17. Father's Name (First, Middle, Last			vala v	Varehouse		's Name (First, Middle		omputer	.8
	ntal od o	Be	John Corneliu						Ava Marie		20,	
Š	d Me d Me nark natic	2	19a. Informant's Name/Relationship			10h Mailin	a Address (Street	and Number	or Rural Route Numb		oue State Zie	Codel
<u> </u>	12 s h an 7 is i								Rockville	-		C00 <del>0</del> )
ב ע	1 and 16alt 9m 2 ther		Mary E. Finnerty, 20a. Method of Disposition	ANTIG	20b. Plac		sition (Name of	Lane,	Date		ion - City or To	wn State
5	ges ritoth oro		1 ☐ Burial 2 ☐ Cremation 3 ☐	Removal from State	cem	etery, cren	natory or other pla					
	men tant: jury		4 ☐ Donation 5 ☐ Other (Speci	(y)	Metr		ematory,				timore,	
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Menth Hygiene. Department of Health and Menth Hygiene. Importent: if item 27 is marked other than "naturel; or items 23a or 28a-f show amportent: if item 27 is marked other than "naturel; or items 23a or 28a-f show apprintry or other traumatic event, the Medical Enal: Let mail by Inclined at ODEs.		21. Signature of Funeral Service Live	ven or ell	,				Cremation			
_	<b>7</b> □ = <b>0</b>		Edward A. 60	egorchik					oad Balti		MD 2122	28
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	plications that caused to one cause on each line	the death.	Do not ente	er the mode of dying	ng, such as ca	ardiac or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	. Gun	965	t.	vound	he	24			Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequer						10	1,5
	Examiner		Sequentially list conditions	b								
-	7 V =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequer	nce of):						
	nd / nd	Examiner	Cause (Disease or injury that initiated events	c								
Š	be executed cician and burial-transit	Ä	resulting in death) Last	Due to (or as a	consequer	nce of):						
200	0 X 0	cal		d						_		
ŏ	ng pl	Physician/Med	IF FEMALE:									
Õ	th ce tendi	an/l	23b. Was decedent pregnant	23c. If yes, outcome of 1 ☐ Live birth 2			Ectopic pregnanc	v		23d	. Date of delive	
	dea deat	sici	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnant at t 9□Unknown			Other (specify)	·			Month	Day Year
יכ	at the by the	بر	9 Unknown	on on one								
'n	gned be de	þ	Part II. Other significant conditions	contributing to death bu	t not resulti	ng in the ur	nderlying cause giv	en in Part I.	23e. Did	tobacco use		e cause of death?
Records	en si	ed	Depressio	120					10	Yes 2□N	lo 3 ☐ Prob	ably 4 Unknown
္ဆ	awre is be 2 sho	Completed	<b>,</b>						24a. Was		4b. Were autop	osy findings available inpletion of cause of
Ĕ	The Ite has	E							perf	22(No	death?	_
A II d	en: tifica tor, p	0	25. Was case referred to medical					26. Place o	of Death (Check only			20.10
>	yalcl is cer direc	.o	examiner? 1 <b>2√</b> es 2□No	Hospital: 1 ☐ Inpatier	nt 2 EP	VOutpatien	t 3□ DOA O#		sing Home 5 Res		Other (Specify	) .
5	er thi	n: T	27. Manner of Death	28a. Date of Injury	/ 28	8b. Time of	28c. Injur	y at			ccurred 5 %/	<del></del>
5	uth. r: Aft	읊	1 □Natural 5 □ Pending 2 □ Accident investigation	n J (Month, Day	2006	P13	DM 1□	Yes 2	· Shot	gun 4	round	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
DIVISION	Atte	블	3 Suicide 6 Could not be determined	28e. Place of Inju	ry - At home				28f. Location	Street and N	umber or Rura	Poute Number, La
5	al or	Certification:	4   Homicide	building, etc.		me			Park		3821 n0	Loree La
	pspit hour: insra y fille		29a. Certifier 1 Certifying P	nysicien: To the best o	f my knowle	edge, death	occurred at the til	me, date and	place, and due to the	cause(s) an	d manner as st	ated.
	To the Hospital or Attending Physicien: The law requires that the death certifica within 24 hours after death.  To the Funaral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as it	Medical	(Check only 2 Medical Exa	miner: On the basis of and manner stat	examination ed.	n and/or inv	estigation, in my o	ppinion, death	occurred at the time	date and pla	ice, and due to	the cause(s)
	To the To the To the Comp	Σ	29b. Signature and title of certifier	_ //			29c. Licens	e number		29d. Date s	igned (Month,	
			Jan 217	secky	mo	OME	Do	0424	6	Jul =	24 2	0006
	10		30. Name and address of person who	completed cause of de	ath (Item 2	За) (Туре,	Print) 2/0/	me	LICAL P.	erk.	Dr	
	6		IRA N BRET	HER, MO	DM	E	Silver	SON	ing m	D	2090	2
	Sta	te	30. Name and address of person who IRA N BRE 31. Date filed (Month, Day, Year)	32 Registra	r's Signatur	9	Trans.	1	0			
	Registr	ar	1111 2 5 20		. K	An	and it					
_			44-			1						

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month 14 2006 **Physician** 0033M JULY Danny Ray Hicks /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMORE ST. AGINES HOSPITAL n/a If Under 1 Year | If Under 24 Hrs. 6. Sex 1 → M 2 □ F 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 212-56-7186 Yrs. 55 1950 West VA 10. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits ir then "natural", or Items 23a or 28a-f ehow the Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No MD Baltimore <u>Halethorpe</u> Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21227 32 Carling Circle USA Funerai filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces?

1 ⊠Yes 2 □ No 1970 If Yes, Give Year or Dates: 1974 13. Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No 3 ☐ Widowed 4 ☐ Wivorced ξ 1974 white white Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) alth and Mental Hygiene. 27 ie marked other then ir treumatic event, the Me Elementary/Secondary (0-12) College (1-4or 5+) Print Setter 12 Newspaper 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) James S. Hicks Bettie Persinger 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 and 2 and 2 permit. Department of Health ar important: if item 27 is eny injury or other treugnore. Drema Rutherford - Sister 8369 Elm Road Millersville, MD 21108 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition
1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Date 20c. Location - City or Town, State 4 □Donation 5 □Other (Specify) July 25, 06 Baltimore, Maryland Metro Crematory <sup>22, Name and Address of Facility
Cremation Society of Maryland, Inc.
299 Frederick Road Baltimore, Maryland 21228</sup> 21. Signature of Funeral Service Ligensee 23a. Part. Enter the disease, or complications that odused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ENDO CARDITIS **Physician** INFECTIVE 5 DAYS /Medical Due to (or as a consequence of): Examiner Schantisty list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine burial-transit The law requires that the death certificate be executed physicien and that initiated events resulting in death) Last Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☑ No 24a. Was an autopsy performed? this certificete 1 Yes 2 No Attending Physician: After this certification funeral director, I 25. Was case referred to medical Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 27. Manner of Death 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 1 Natural 5 Pending death. 1 Tes 2 No investigation 2 Accident within 24 hours efter death To the Funeral Director: , completely filled in by the f 6 Could not be determined 28e. Place of Injury - At home, larm, street, lactory, office building, etc. (Specify) 3 ☐ Suicide 281. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide ö Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29c. License number 29b. Signalur and title of certifier 18606 Tu/v 24,20de 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) n AVE. BALTIMORE, MD 21229 900 CATON AFSA 31. Date liled (Month, Day, Year) 32. Registrar's Signature State Registrar 2006

DHMH 17 Rev 1/2001

ICKS, DANIEL

ORIGINAL

# Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Manyland / Department of Health and Mental Hygiene

			For State of Maryland / Department of Health ar  1 - State Registrar Certificate of Death	na iviei	, ,	ene 200 (	5 23241
	Physicia	an	Decedent's Name (First, Middle, Last)		Date of Deat Month	Day Year	3. Time of Death
	/Medic	al	Elsie Hairston  4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of I		July	24, 2006 4c. County of Dea	
	Examin	er	14032 Breeze Hill Lane Silver Sprin			Montgomer	
	Funeral Director		5. Social Security Number  6. Sex 1 Months Days Hours 234-70-9017  6. Sex 7. Age (In yrs. last birthday) 1 Months Days Hours	4 Hrs. 8. Min. 9	Date of Birth (Month, Day, /24/19(	9. Bi 08 Cas	rthplace (State or Foreign country)
pool	Mo m		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Location				10d. Inside City Limits
Man	he lifted	ctor	MD Montgomery Silver Spring				1  Yes 2 □ No
the state of the s	or 28	Dire	10e. Street and Number 10f. Zip Code		11	0g. Citizen of What C	
400	na 23e	Funeral Director	14032 Breeze Hill Lane     20906       11. Marital Status     12. Was Decedent Ever in U.S. Armed Forces?     13. Was Decedent of Hispanic Origin If Yes, specify Cuban, Mexican, Me	in? (Specif	v Yes or No-	United St	
U. Z. I. Z. I. O. O. O. O. O. O. O. O. O. O. O. O. O.	A Hautu and Mantal Hygiene. Health and Mantal Hygiene. them 27 is marked other than "naturel", or items 23s or 28s-1 show other traumatic event, the Medical Examinar most be invitted at	þ	Armed Forces?  1 Never Married 2 Married  1 Yes 2 No If Yes 2 No If Yes 2 No If Yes Correct  1 Yes 2 No 1 Yes	Puerto Ric	án, etc.)	Specify: B1	
	natur	eted	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	of working		16b. Kind of Busines	s/Industry
7	n and Mental Hygiene. 7 ie marked other than ".	Completed	Elementary/Secondary (0·12) College (1-4or 5+) Homemaker			Domestic	
	other vent,	Be C	17. Father's Name (First, Middle, Last)  18. Mother's			Maiden Sumame)	
2 2	Menta arked	To	John Taylor Hairston Easter				
	th and th and traum		19a. Informant's Name/Relationship (Type, Print)  Bernice H. Brown (Daughter)  19b. Mailing Address (Street and Number)  6161 First Place N.			City or Town, State, $con, DC 2$	
ָם מו	permit. rages land Department of Health Important: if Item 27 any injury or other tru once.		20a. Method of Disposition  1 Burial 2 Cremation 3 Aremoval from State  4 Describes 6 Chec (Secrib)  20b. Place of Disposition (Name of cametery, crematory or other place)  Restlawn Memorial 7	Date	9	20c. Location - City of	r Town, State
Dallillo	partme sortan / injur		21. Signature of Funeral Service from See 22. Name and Address of Facility				
Ď :	Depa impo any ir		Luhal though II 3401 Bladensbur			entwood,	1
P	hysician		23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cashock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition	ardiac or re	espiratory arre	est,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
Ŀ,		ler	Sequentially list conditions, if any, leading to him rediate cause. Enter Underlying Cause (Disease or injury				
1	nd transit	Examiner	that initiated events C.				
5	physicien and as the burial-transit	al Ex	Due to (or as a consequence of):				
00/00	physical by the last	edical	d	,			
DOX	e attending d for use a	Completed by Physician/M	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yas 2 ☒ No 9 ☐ Unknown  23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 3 ☐ Ectopic pregnancy 4 ☐ Pregnant at time of death 5 ☐ Other (specify)			23d. Date of d Month	elivery Day Year
L	requires that the een signed by the hould be detache	y Pr	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tot	pacco use contribute	to the cause of death?
cords	adulra aen sig	ted t	Chronic Renal Failure	_	1 □ Y€	es 2 🟋No 3 🗆 I	Probably 4 Unknown
	ate has be	Comple			24a. Whas a autops perform	ned?   death?	autopsy lindings available completion of cause of s 2 \square No
\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	certific rector,	Be	examiner? V Hospital: Other		Check only on		
5 8	grinya erthis eraldi	To	27. Manner of Death 28a. Date of Injury 28b. Time of 28c. Injury at			ence 6 Other (Sp ow injury occurred	ecify)
	aath. or: Afte	atio	2 Accident investigation M 1 Yes 2 No	lo			
DIVISION	al or Attending Frivillant. Is after death. Is Director: After this certificat ad in by the funeral director, pr	Certification;	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	281	Location (St City or Town	reet and Number or I n, State)	Rural Route Number,
:	to the frozing of Appareding Frigstrient. The lar within 24 hours aller death.  Within 24 hours aller death.  No the Funeral Director: After this certificate has completely filled in by the funeral director, page 2.	edical	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, death occurred at the time, date and manner: On the basis of examination and/or investigation, in my opinion, death and manner stated.	I place, and h occurred	d due to the ca at the time, d	ause(s) and manner ate and place, and d	as stated. ue to the cause(s)
	Some state of the	Σ	29b. Signature and title of certifier  Mathe Slawedic  29c. License number  D 41173			9d. Date signed ( <i>Mol</i>	กเก, Day, Year)
10	1		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  10301 Georgia Ave Silver Spring, MD 20902				
	Sta Registr		31. Date liled (Month, Day, Year)  JUL 2 5 2006  Registrar's Signature				

		•	for State Registrar	State of Marylar		artment of rtificate o		nd Menta	l Hygien	ZIIIIb	23242
S	Physici	an	1. Decedent's Name (First, Middle, La	241 0				2. Date	of Death	ay Year	3. Time of Death
	/Medic Examin	al	4a Facility Name (If not institution, give Millenium Hea		ab	4b. City, Town	n, or Location of I	Death		c. County of Death	12/19
	Funeral Director		5. Social Security Number 6. S	7. Age (In yrs.	/ / Yrs.	If Under 1 Ye Months Day		Min. 8. Date	of Birth onth, Day, Year	9. Birth Cou 065 Maj	place (State or Foreign ntry) Y/2na
	Maryland a-f ahow	ctor	10a. State 10b. County  MD NA		ity, Town or Lo 2 Himor						10d. Inside City Limits 1 ✓ Yes 2 ☐ No
	ath with the 23a or 28 unt be not	Funeral Director	10e. Street and Number 4017 Liberty F	teights Ave.		10f. Zip Code 2/6	215		US		
980	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f ahow important: If Itam 27 is marked other than "natural", or Itams 23a or 28a-f ahow hy Injury or other traumatic avant. Ita Mudical Examining Lustified at once.	þ	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:		Was Decedent of If Yes, specify C	of Hispanic Origin Cuban, Mexican, F No <i>Specify:</i>	n? (Specify Ye Puerto Rican, e	s or No- atc.)	14. Race - Ameri Black, White, Specify: Bla	
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_	1 and 2 sho Health and tam 27 la mu		19a. Informant's Name/Relationship ( Ruth Young - Gr 20a. Method of Disposition	randmother 2006.	3600 Place of Dispo	Allendo	dale St.	22 .	B Ba	or Town, State, Zi Himore, L Location - City or T	no 21229
Baltimore,	permit. Pages Department of i Importent: If its any Injury or o once.		1 Burial 2 Cremation 3 4 Donation 5 Other (Special Signature) Funeral Service Lice	(y) ME	tro Cre	emotory or other personal conditions of the conditions of the conditions are seen and additional conditions of the condi		24-06		onsville,	11129
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	Physician /Medical Examiner		shook, of heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Acquire  Due to (or as a conse	d im		define		ryndr	ine	Interval Between Onset and Death
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Il Records,	The ate h	Completed							a. Was an autopsy performed? Yes 227	prior to co death?	opsy findings available ompletion of cause of
Vital	sician certifi irector	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital: ↑ Inpatient 2	T EP/Outpation	at 2000		f Death (Chec		6 □Other (Speci	4.1
of o	ng Phy Iter this ineral d	ation: To	27. Manner of Death 1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	f 28c. li	njury at Work?	28d. De	scribe how in		ny)
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	within To th	Me	29b. Signature and title of certifier  Mian-0	Kiong m			ense number			ate signed (Month)	
7	2		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type.		03186			7/24/0	
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		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or L	Location of Death		4c. County of Death	
		2907 Dunmurry Road, Apartment C Dundalk			Baltimore Cou	inty
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year	If Under 24Hrs.	8. Date of Birth(	MM/DD/YYYY) 9. Bir	
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nours	Di Di	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation during most of working life.			6b. Kind of Business/I	
136 hin 72 hou e than "nat	et	Elementary/Secondary (0-12)  College (1-4 or 5+)	4	1	Redero	il
5-0036 led within 72 hours after Hygiene other than "natural", the Medical Examiner	Completed by	12th N/A ACCOUNT	ntan		Rese	rve
5-00 led with Hygiene other	ပ္ပါ	17 Father's Name (First, Middle, Last)	8.Mother's Name	(First, Middle, Mai	den Surname)	4
21215-0036 uld be filed within 72 hours after death with the Maryland Mental Hygiene marked other than "natural", or items 23a or 28a-f she e event, the Medical Examiner must be notified at once	Be	William Jasper	Carl	ine	Conr	ad
- p = e 2	2	19a, Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street	t and Number or F	2	r, City or Town, State	, Zip Code)
		Gerald James In- In 317 Hillere	st Rd.	Balto	imd, 2	1225
e, M and 2 Health item 2		20a. Method of Disposition 20b. Place of Disposition (Name of cern	netery,	Date 2	Oc. Location - City or	Town, State
F 드 유 드		1 Burial 2 Cremation 3 Removal from State crematory or other place)	to 17-	27-01 1		. 10
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Baltimore permit Pages 1 s Department of He Important: If it injury or other t		21. Signature of Funeral Service Licensee 22. Name and Address	of Facility 27	O Fred H	- (Lion Pa	ase
m Fore		Varit 18 1/and San P. C	Narch	Fineral	Home Bab	to, md,21229
Physician		23a. Part I/Enter the disease, of complications that caused the death. Do not enter the mode of dying,	such as cardiac o	r respiratory arrest,	, shock, or heart	Approximate Interval
/Medical		failure. Vist only one cause on each line.  Immediate Cause (Final disease a Hypertensive Atherosclerotic Cardiovascular Dise	e25e			Between Onset and Death
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876 ifica ig ph	F	23b. Was decedent pregnant in the 1 Live birth 2 Fetal death 3	Ectopic pregna	ancy		Day Year
cert r cert endii	cia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)				
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The de by the ched f	۳	Part II. Other significant conditions contributing to death but not resulting in the underlying cause gi	iven in Part I.	23e. Did toba	cco use contribute to	the cause of death?
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Division of Vital Records, P.O. Box 68760, within 24 hours after death certificate be within 24 hours after death.  To the Funeral Director. After this certificate has been signed by the attending physic completely filled in by the funeral director, page 2 should be detached for use as the burn	Be	examiner? Hospital:   Insertingt 3 FR/Outpetingt 3 POA	Other		esidence 6 🗸 Other	r: Scene
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losp 4 hou mre ely fi		29a. Certifier	ate and place, and	due to the cause(s	s) and manner as star	ted.
To the Hos within 24 h To the Fun completely	ica	(Check only one)  2  Medical Examiner: On the basis of examination and/or investigation, in my opinion,				
To t with To com	Medical	and manner stated  29b Signature and title of certifier  29c License			9d. Date signed (Mo.	
	_	10		1		, 5a,, (6a)
d		California O.C.M	VI.⊏.	'	July 22, 2006	
, , ,		30. Name and address of person who completed cause of death (Item 23a)				
H		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Balti	imore, MD 21	201		
9	tate	31. Date filed (Month, Day, Year)  1111 2 5 2006	<del></del> -			
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ORIGINAL

Please pe or Print in Black Indelible Ink. Ensure All Copies Are Legible.

State of Maryland / Department of Health and Mental Hygiene 2 1 - State Amend item#4b, perMD, g857,7/25/06 TT Certificate of Death

Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Physician 2006 /Medical 4a. Facility Neme (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 2100 Towson If Under 24 Hrs. Age (In yrs. last birthday) If Under 1 Year 8. Date of Birth (Month, Day, 9. Birthplace (State or Foreign Country) **Funeral** 1□M 2M Months Days Hours Director Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location or 28a-f ahow a notified at 10b. County 10d. Inside City Limits WindsorMil Bultimore 1 ☐ Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? il Hygiene. cother then "neturel", or itema 23e or ! vent, the Medical Exactine crust be ! Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. Peges 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1□ Yes 2 No Baltimore, Maryland 21215-0036 Specify: Black 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Ith and Mental Hygi 27 is marked other r traumatic avent, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Koberts Vai mond 2 19a. Informant's Na e/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health ar important: If Itam 27 is any injury or other trau 7168 Neville ct 1Husband Windsormill MD 21244 Harris 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 22/06 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Vacigna 8728 Liberty Tech MO 91133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or head failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ears /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence of Examine or Attending Physician: The law requires that the death certificate be executed burial-transit physicien and Due to (or as a consequence of) P.O. Box 68760, Physician/Medical the IF FEMALE: esu. 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy ò in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) signed by the a Id be detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? s certificete has t lirector, page 2 s autopsy performed 2 No 1 Yes 2 No 1 Yes director 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 1 Yes 2 No Other: 4 Nursing Home 5 Residence 6 Other (Specify) Medical Certification: To 2 ER/Outpatient 3 DOA After the 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No within 24 hours after death To the Funeral Director: / completely filled in by the f 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide To the Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29c. License number 29d. Date signed (Month, Dey, Year) 29b. Signature and title of certifier 25205 30. Name and address of person who completed cause of death (I)em 23a) (Type, Print) Charles St. Balks and 6701 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 5 2006 Registrar

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		State of Maryland / Department of He		1, 0
		Registrar Certificate of D		70
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altim mit. Pa internet		4 Donation 5 Other (Specify)  21. Signature of Juneral Service Licensee  22. Name and Address		
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		(Initia Suntaum MD RES	5-000 July 21, 2006	
		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	11 - 1 0 000	
·		Anitra Birnbaum, MD SI	mai trospital of Baltimore	
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			Registrar  1. Decedent's Name (First, Middle, Las	it)	Cei	rinicale of	Deam	2. Date of Dea		3. Time of Death
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ylan	D & 0	ToE			101 11		1500	belle	61000	7. 0. 1.
Mary	nd 2 shoul Ith and Mo 27 le marl traumatl		19a. Informant's Name/Relationship	. /	190. Mailii	562		2	r, City or Town, State, I NIC MD	21000
ore,	es 1 and of Healt fitem 2 r other		20a. Method of Disposition  1 Burial 2 Cremation 3	20b. P		osition (Name of matory of other pla		Date	20c. Location - City or	Town, State
altimor	0 0		4 Donation 5 Other (Specif	)	edoir		7/5	3/06 (	Glen Burn	e mo
Bal	permit. Par Departmen Important: eny injury once.		21. Signature of Funeral Service Licer	C	8	728 Lib	krty Ra	Rosdo	Lesteun 1	10 21132
#2	X S		23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death	h. Do not ent	ter the mode of dy	ving, such as cardia	or respiratory and		Approximate Interval Between
24	Physician		Immediate Cause (Final disease or condition resulting in death)	MYOCAK	DIA	rL 11	NEAR	C770	N	18 DAYS
	/Medical Examiner		resulting an dealth)	CO CO A	uence of):	ARTI	=RY	DUSE	ARE	124 FARS
	n\1/ =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or as a conseq	uence of:	- ( ) i	1/11/4	DED	TENO	1167000
	be executed icien and burial-transit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c. Due terfor as a conseq	uence of):	1146	179	VER	1 LAYYON	110 (EHK)
760,	ite be ex iysicien he buria	icai E		CHRONIC	206	STRU	CTIVE	PVLM	OMARY	20YEARS
99		Medi	IF FEMALE:					1717	EASE	( ,, _
Вох	death certific attending pl	cian/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d	Ideath 3	☐Ectopic pregnan ☐ Other (specify)	су		23d. Date of del Month	livery Day Year
P.0.	at the de by the a tached i	Physician/Med	1 Yes 2 No 9 Unknown	9 Unknown						
	ires tha signed I I be det	þ	Part II. Other significant conditions of	ontributing to death but not res	ulting in the u	inderlying cause g	iven in Part I.		es 2 No 3 Pr	o the cause of death?
Records,	w require been si should I	Completed						24a. Was a	an 24b. Were au	atopsy findings available
Re	The lav	omo						autop perfor	rmed? prior to death?	completion of cause of 2 □ No
Vital	Physician: Th this certificate ral director, pag	Be	25. Was case referred to medical examiner?	Hospital:			thor	ath (Check only		
of	Phys r this ral di	n: To	1 ☐ Yes 2 No 27. Manne of Death	1 ☐ Inpatient 2 ☐  28a. Date of Injury (Month, Day Year)	28b. Time o	IL 3 DOA	4 🗀 Nursing r		lence 6 Other (Spe	cify)
sion	Attending For death.  ector: After by the funera	atio	1 Natural 5 Pending 2 Accident investigatio 3 Suicide 6 Could not b	ו	Injury		ork? □Yes 2□No			
Division	5 5 t c	Certification:	3 Suicide 6 Could not b	28e. Place of Injury - At he building, etc. (Specif	ome, farm, st	reet, factory, office	Э	28f. Location (S City or Tow	Street and Number or Ri In, State)	ıral Route Number,
_	To the Hospital or Attent within 24 hours after deatl To the Funeral Director: completely filled in by the			tysicien: To the best of my kno niner: On the basis of examina						
	the Hin 24 the Fi	Medicai	one)  29b. Signature and title of certifier	and manner stated.	MION AND ON	29c. hicer			29d. Date signed (Mont	
	To Too		Herry	tingh 1	Q-N	1	21416	0	ULY21,	2006
	4		30. Name and address of pelson wito	completed caree of death (tai	n 23a) (Type,	P. 5	410-1	ARI-	TCHIE	HIG HWAY
100	V	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signa	iture	_ 3	ALTI	MORE	E, Md.	21220
	Regist		.1111 2 5 201		K An	sells?	-			(

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For Stete Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** :30/p M KOMONA Tunlen Jeel 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Home NURSING BAIT: MOre
If Under 1 Year | If Under 24 Hrs. CARC FUMERE 7. Age (In yrs. last birthday) 6. Sex Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1□M 2**/** F Hours 214-26-0057 Director Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State other treumatic event, the Medical Examiner must be notified at Yes 2 □ No Completed by Funeral Director BAITIMORE M. 10f. Zip Code 10e. Street and Number 10g. Citizen of What Country? 963 N. ChesTen ST U.S.A. 12. Was Decedent Ever in U.S. Armed Forces?

1 ☐ Yes 2 ☑No
If Yes, Give
Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ö 1 ☐ Yes 2 No Specify: Specify: B/ACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) WORKER HOUSE WORK 11 grade None 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be item 27 is marked of Chauncey Doles DMMA loung 19a. Informant's N e/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) N. Chester BATTIMORE M. Hade 20c. Location - City or Town, State John HunTer 963 21205 20b. Place of Disposition (Name of /cemetery, crematory or other place) Date 20a. Method of Disposition ŏ <u>∓</u> 1 Burial 2 Cremation 3 Removal from State ŏ Department of Importent: If any injury or once. ouden PR. Come. \*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Betts Funeral Folsiera ST. BAITIMORE 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician End Stage 20 disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** bestinden Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for s a consequence of). Physiclan/Medical Examiner The law requires that the death certificate be executed Vialutes IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 4 Pregnant at time of death ģ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Donknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an 2 No 1 ☐ Yes Hospital or Attending Physician: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Certification: To filled in by the funeral 27. Manner of Death 1 Natural 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Division 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident To the Hospital or Attend within 24 hours after death (To the Funerel Director: 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical

State Registrar

31. Date filed (Month, Day, Year) JUL 2 5 2006

29b. Signature and title of certifier

(Check only one)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DARSHAW SSSALV/II 1600 W. MOUNT Royd Aw, 32 Registrar's Signature

and manner stated

29c. License number

29d. Date signed (Month, Day, Year) 7-21-06

06-05245 Daniel Iler

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

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		1- For State Registrar	Certi	ficate of Death		Reg	g. No.	0 2324
Physicia ledical Examir	ın/ ner	1. Decedent's Name (First, Middle,	Fler			July 20, 20	Day Year 06	3. Time of Death 0956 hrs
		4a. Facility Name (if not institution, Mercy Hospital	give street and number)	4b. City, Town Baltimore	n, or Location of Deat e City	th	4c. County of Death	
Funeral Director		213-52-5867	7. Age (In yrs. last		Year If Under 24Hi Days Hours Mi	_	(MM/DD/YYYY) 9. 8in Foreig Co	thplace (State or unitry) (3 nd
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Director	Usual Residence of Decedent  10a. State  10b. County  10e. Street and Number  5 Zo 5 Dace	Variok Circ	own or Location  The over 10f. Zip Cool	1237	10	g. Citizen of What Cou	10d. Inside City Limits 1
hours after "natural", Examiner	by Fune	11. Marital Status 1 Never Married 2 Mar 3 Widowed 4 Divor 15. Decedent's Education (Special Elementary/Secondary (0-12)	12 Yes 2 No red if Yes, Give Year - 1976		No specify:  upation (Give kind of	o Rican, etc.)	14. Race - Ameri White, etc. Specify: 6 10	can Indian, Black,
nore, MD 21215-0036 ges 1 and 2 should be filed within 72 hours af nt of Health and Mental Hygiene it: If Item 27 is marked other than "natural other transmatic event, the Medical Examin	Be Completed	17 Father's Name (First, Middle, L	ast)	labo		e (First, Middle, M	Contra giden Surname)	ctor
b, MD 21; and 2 should b fealth and Men item 27 is mar traumatic eve	٩	19a Informant's Name/Relationshi	tardy Sister 200. Pla	19b. Mailing Address (S	ubrook	Rufal Route Numb	Ballo A	Zip Code)  41. 212.3 7  Town, State
Baltimore, MD 21215-00; pemit. Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tinjury or other traumatic event, the Mechanical Content or other traumatic event or other traumatic		1 Burial 2 Cremation 4 Donation 5 Other Spe 21 Signature of Funeral Service	cify: Gar	ematory or other place)  PM 10 2- Fore-  22 Name and Add	Voi Con. Ju	28 204	Baldo. 1	2. P. A.
Physician /Medical Examiner		23a. Part I. Enter the disease, or c failure. List only one cause o Immediate Cause (Final disease or condition resulting in death)		no not enter the mode of dy	ing, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval 8etween Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	b. Alcohol abuse  Due to (or as a consequence of):  c.			- **		
kecuted n and - transit		events resulting in death) Last	Due to (or as a consequence of):					
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and Completely filled in by the funeral director, page 2 should be detached for use as the burial - transitions.		W UNPENDED  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unkn	23c. If yes, outcome of pregna  1 Live birth  4 Pregnant at time of death	2 Fetal death	9/21/06 TT 3	nancy	23d. Date of delivery Month E	lay Year
cords, P.O. E law requires that the has been signed by the 2 should be detached.	Completed by Ph	Part II. Other significant condition	ons contributing to death but not resu	ulting in the underlying cau	ise given in Part I.		y prior to o	
ital Recor ician: The law certificate has b		25. Was case referred to medical	7	26.P	lace of Death (Check	1 ✓ Yes 2		s 2 No
F Vita Physicia ar this ce	To Be	examiner?  1 ✓ Yes 2 No	Hospital: 1 Inpatient 2 V E				Residence 6 Other	
Division of Vital Records, ral or Attending Physician: The law requirins after death.  "al Director: After this certificate has been sited in by the funeral director, page 2 should the fine funeral director, page 2 should	Certification:	27. Manner of Death  1 X Natural 5 Pendii 2 Accident Invest	(Month, Day, Year)	1[	Injury at Work?  Yes 2 No		ow injury occurred reet and Number or Ru	ral Pauto Number City
Divisior Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	Certifi	4 Homicide determ	not be nined (Specify)			or Town, Sta	ate)	
To the Hos within 24 h To the Fur	Medical	(Oncor oray	vsician: To the best of my knowledge siner: On the basis of examination and					
V Beck	Me	29b. Signature and title of certifier	and manner stated.	0	cense number		29d Date signed (Mor	ith, Day,Year)
100		Sugan Hagan MD	yho completed cause of death (Item 23 ssistant Medical Examiner	111 Penn Street, E		1201		
St Regist	ate trar	11 71 57	5 200 32. Registrar's Signature	1. Aprile	1			

06-05297 Arthur Johnson

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

attilai soilisoii		- For State Criticate of Death legistrar		teg. No. 200	5 23210
Physicia	n/	1. Decedent's Name (First, Middle,Last)	Date of Dea     Month		3' Time of Death 1205 hrs
Medical Examin		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Loca	Month July 21, 2	2006 4c. County of Death	
		3000 Towanda Avenue Apt. 115 Baltimore		NIA	
Funeral		of Coolar Coolarity Training		rth (MM/DD/YYYY) 6. Bir Foreig	thplace (State or
Director		$214-30-3116$ 1 MM $2\square F$ $72$ Yrs. Months Days	Hours Min May		untry) Md.
à		Usual Residence of Decedent  10a. State 10b. County / 10c. City, Town or Location	/		10d. Inside City Limits
ow any		Maryland NA Baltimore			1 Yes 2 No
daryland 28a-f show 1 at once.	핡	10° Zin Codo		10g. Citizen of What Cou	ntry?
ith the Maryland 23a or 28a-f sho notified at once.		3000 Towanda Ave. Apt 212	15	USF	<del>]</del>
h with ms 23 be no	Funeral Director	Armed Ferrance If Von appoint Culture Mo	o Origin? (Specify Yes or Na xican, Puerto Rican, etc.)	o- 14. Race - Amer White, etc.	can Indian, Black,
or ite	Fun	1 Yes 2 No		Specify: R	ack
ırs afte	화	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (	Give kind of work done	16b. Kind of Business/	Industry
72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	NOT use retired)	11/ /	4
within ene er tha	팂	12 0 Truck Dr	other's Name (First, Middle,	Nu Car	Carriers
21215-0036 build be filed within 7 Mental Hygiene marked other than	Be Co	17. Father's Name (First, Middle, Last)	other's Name (First, Middle,	Minshire h	
212 ould be Menta mark		19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and	Number or Rural Route Nu	mber, City or Town, State	, Zip Code)
MD nd 2 sho alth and m 27 is		Ms. Karen Mitchell 1/00/ Deer	field Kd	. Balto. N	1d. 21208
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f 3h injury or other traumatic event, the Medical Examiner must be notified at once		20a Method of Disposition  1 Burial 2 Cremation 3 Removal from State crematory or other place)	7/2/2007	20c. Location - City or	Town, State
Baltimore, permit Pages I an Department of He Important: If ite		4 Donation 5 Other Specify: Bayung (remato	M1/21/2006	Dunda	JK, Ma.
Balt permit Depar Impon	ļ	22 Signature of Funeral Privice Licenses 122 Name and Address of Funeral Privice Licenses 122 Name and Address of Funeral Privice Licenses 122 Name and Address of Funeral Privile Licenses 122 Name and Address of Funeral Privile Licenses 122 Name and Address of Funeral Privile Licenses 122 Name and Address of Funeral Privile Licenses 122 Name and Address of Funeral Privile Licenses 122 Name and Address of Funeral Privile Licenses 122 Name and Address of Funeral Privile Licenses 122 Name and Address of Funeral Privile Licenses 122 Name and Address of Funeral Privile Licenses 122 Name and Address of Funeral Privile Licenses 122 Name and Address of Funeral Privile Licenses 122 Name and Address of Funeral Privile Licenses 122 Name and Address of Funeral Privile Licenses 122 Name and Address of Funeral Privile Licenses 122 Name and Address of Funeral Privile Licenses 122 Name and Address 122 Name and Address 122 Name and Address 122 Name and Address 122 Name and Name	Russ Fuy	zeral Hom	e, P.A.
Physician		23s. Part I. Enter the disease, or complications that saused the death. Do not enter the mode of dying, such failure. List only one cause on each line.	as cardiac or respiratory ar	rest, shock, or heart	Approximate interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease a. Atherosclerotic Cardiovascular Disease complicate	d by hyperthermia		Death
		or condition resulting in death)  Due to (or as a consequence of):			
	آو ا	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):			
11/	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death). Last			
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Box 68760, e death certificate be executed the attending physician and ed for use as the burial - transit	Medical	UNPENDED AMENDED			
3760 ificate ig phys		IF FEMALE: 23b. Was decedent pregnant in the page 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 E	ectopic pregnancy	23d. Date of deliver Month	y Day <b>Y</b> ear
X 68 th cert ttendir r use a	icia	past 12 months?  4 Pregnant at time of death 5 Other (Specify)			
. 4 >4	Physician	Part II. Other significant conditions contributing to death but not resulting in the underlying cause giver	in Part I. 23e. Did	tobacco use contribute to	the cause of death?
P.O es that to igned by be detac	ð	diabetes mellitus		es 2 🗸 No 3 🗌 Pro	bably 4 Unknown
'ds, require been si	Completed		24a Was		utopsy findings available completion of cause of
ecol ne law te has ge 2 sł	dmc		perf	formed? death?	
an: The Entification, pa	Ö	20. 1740 0400 10101104 10 11101101	Death (Check only one)		
Vit;	To B	examiner?  1 V Yes 2 No Hospital: 1 Inpatient 2 V ER/Outpatient 3 DOA Oth	, tarening rights	Residence 6 Othe	r
Division of Vital Records, Hospital or Attending Physician: The law require 24 hours after death. After this certificate has been si rely filled in by the funeral director, page 2 should b	on:	27. Manner of Death  1 Natural 5 Pending  28a Date of Injury 28b. Time of Injury 28c. Injury at FOUND: Day.Year)  FOUND: Day.Year)  FOUND: Towns 1 Yes	Subject for	e how injury occurred ound in a hot en	vironment
ivision or Attend after death. Director:	icati	2 Accident Investigation Jul 21, 2006 1150 hrs 28e Place of Injury - At home, farm, street, factory, office build		(Street and Number or R	ural Route Number, City
Div ital or urs after ral Dis	Certification:	3 Suicide 6 Could not be determined (Specify) Multi-Family Apt.	3000 Towa	<sup>State)</sup> anda Ave, Baltimor	e City, MD
Division of Vital Records, P.C me Hospital or Attending Physician: The law requires that within 24 hours after death. The tribs certificate has been signed to ompletely filled in by the funeral director, page 2 should be deta	Sal	29a Certifier (Check only Certifying Physician: To the best of my knowledge, death occurred at the time, date a	and place, and due to the car	use(s) and manner as sta	rted.
To the Hosp within 24 hor To the Fun completely in	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, de and manner stated  29b. §ignature and title of certifier 29c. License no		29d Date signed (Mo	
	2	O.C.M.E		July 22, 2006	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
		30. Name and address of person who completed cause of death (Item 23a)	<u> </u>		
3	t R	Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Balti	more, MD 21201		
	tate	11 11 11 11 11 11 11 11 11 11 11 11 11			
Regis	trar	JUL 40 2000 Paragram			

			1 - For State Registrar	State of Maryland		nt of Health and te of Death		7000	23250
	Physici /Medic		1. Decedent's Name (First, Middle, Last)	Tohnso	n		2. Date of Death Month	Pay 2 Year	3. Time of Death A
	Examir		4a. Facility Name (Il not institution, give 833 W. Pra	ett St. 31:	3 1	Town, or Location of Dea	re	c. County of Dea	A
a de	Funeral Director		5. Social Security Number 6. Sept 213-18-6324 1C Usual Residence of Decedent	7. Age (In yrs. last	t birthday) If Unde Yrs. Months	r 1 Year* If Under 24 Hr Days Hours Mir		7/3 M	thplace (State or Foreign puntry)  Aryland
	ne Marylan Ba-f show	ctor	Maryland 10b. County / A	10c. City, T	Fown or Location altim	ore			10d. Inside City Limits 1 X Yes 2 □ No
	eath with the 1s 23s or 2 must be no	Funeral Director	833 W. Pra-	H St. Apt. 312. Was Decedent Ever in U.S.		21201		US  14. Race - Ame	A
980	ours after d raf, or Item Examiner	þ	1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	If Yes, spe	dent of Hispanic Origin? ( orify Cuban, Mexican, Pue 2 <b>2</b> No Specify:	rto Rican, etc.)	Black, White	lack
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Department of Health and Mental Hyglene. Important: if Item 27 is marked other than "naturel", or Items 23e or 28e-f show early highly or other traumatic event, he Madical Expirit art must be notified at once.	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation 1 a completed) College (1-4or 5+)	(Give kind of wo	ork done during most of we	orking 16b.	Kind of Business	Industry
	should be filed within of Mental Hygiene. marked other than imatic event, the Market than the matter event.	To Be Co	17. Father's Name (First, Middle, Last)	STOV	rapi	18. Mother's Na	me (First, Middle, Maide	MOA	la
, Maryland	1 and 2 should Health and Men em 27 is marke		19a. Informant's Name/Relationship (Ty) MS. Monica J	ohn Son	1100 E	S (Street and Number or F	ural Route Number, City	or Town, State, 2	d. 21201
Baltimore,	permit. Pages 1 Department of H Important: If Itel any injury or ott		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	e of Disposition (Na. etery crematory or o	m Park 7/2	Date 2006 A	Location - City or butu	Town, State
Bal	permit. Departr Importr any inj		21. Signature of Funeral Services License	L. Kuss	Joseph 2222	nd Address of Facility  LRUSS  WINCHLA	Funeral to	ome, P.F.	Approximate
) i,	Physician /Medical		shock, or heart falure. List only on Immediate Cause (Final disease or condition resulting in death)	e cause on each line.  MULTIP  Due to (or as a consequen	LE MYE		c of respiratory affect,		Interval Between Onset and Death  Co MONTHS
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8760,	cate be executed physician and s the burial-transit	ai Examiner	Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequen	ce of):				
Box 687	eath certificate attending phys for use as the	n/Medicai	IF FEMALE: 23b. Was decedent pregnant	3c. If yes, outcome of pregnancy				23d. Date of deli	Werv
o	that the death cered by the attendin	Physician/Me	in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	1□Live birth 2 □ Fetal deaddeath 4□Pregnant at time of death 9□Unknown	5 ☐ Other (sp	pecity)		Month	Day Year
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	n: The law ficate has t or, page 2 s	e Completed	OF Weep coordinate to adjust				24a. Was an autopsy performed?	death?	topsy findings available completion of cause of
<u>=</u>	ysicla iis certi directo	To Be	25. Was case referred to medical examiner?  1 □ Yes 250 No H	ospital: 1  Inpatient 2 ER/	Outpatient 3☐ DC	Other	ath Check only one lome 5 Residence	6 ∏Other (Spec	cufv)
Division of Vital	uttending Pr death. ctor: After th y the funeral		27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	b. Time of 2 Injury M	Rec. Injury at Work? 1 ☐ Yes 2 ☐ No	28d. Describe how inju		
DİVİ	To the Hospital or Attending Physicien: The law within 24 burus after death. To the Funeral Director: Atten this certificate has completely filled in by the funeral director, page 2	Certification:	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At home building, etc. (Specify)			28f. Location (Street a City or Town, Stat	(0)	
	ne Hosp n 24 ho ne Fune bletely f	Medical	29a. Certifier 1 Certifying Phys (Check only one) 1 Medical Examin	icien: To the best of my knowled er: On the basis of examination and manner stated.	dge, death occurred and/or investigation	at the time, date and place, in my opinion, death occi	e, and due to the cause(s arred at the time, date an	) and manner as d place, and due	stated. to the cause(s)
	To the P within 24 To the F complet	Σ	29b. Signature and title of certifie?	Legnon 14:	$\mathcal{O}$ .	License number		ate signed (Month	n, Day, Year)
	3		30. Name and address of person who con	mpleted cause of death (Item 23: $+\mathcal{E}_{VM}AVM$ .	a) Type, Print)	·	*	/	
	Sta Registra	200	31. Date filed (Month, Day, Year)	32. Registrar's Signature					

#### 06-05274 UNK UNK

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

cia Johnson	F	Registrar	Re	g. No. 200	6 2325
Physiciar	<b>1/</b>	1. Decedent's Name (First, Middle,Last)	Date of Death     Month	Day Year	3. Time of Death
Medical Examin		Mileta domison	July 20, 20	06	2121 hrs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death		4c County of Deat	h
	3611 Liberty Heights Avenue Baltimore				
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min.	-	Forei	rthplace (State or
Director	-	217-92-1760 1 M 2 F 27 Yrs. World's Days Flod's Will.	03/22/	1979 c	gn Maryland ountry)
		Usual Residence of Decedent			
v amy	- 1	10a. State 10b. County 10c. City, Town or Location			10d. Inside City Limits
and show	ы	Maryland Baltimore			1 X Yes 2 No
ne Maryland or 28a-f show any fred at once.	uneral Director	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	intry?
the Na or	ਙੋ∣	5238 Park Heights Avenue 21215	1	U.S.A.	
ms 23	al 	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specific Specific	14. Race - Ame White, etc.	ican Indian, Black,	
death or ite	Š١	Armed Forces?  If Yes, specify Cuban, Mexican, Puerto I  Yes 2 No	Nicari, etc.)	vvilite, etc.	
after	g F	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:		Specify: B1a	ack
ours	Maryland  10e. Street and Number  10e. Street and Number  10e. Street and Number  10e. Street and Number  10e. Street and Number  10e. Street and Number  11e. Marital Status  11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Yes or Nolif Yes, specify Cuban, Mexican, Puerto Rican, etc.)  14. Race  White  15. Decedent's Education (Specify only highest grade completed)  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Decupation (Give kind of work done during most of working life. DD NDT use retired)  17. Father's Name (First, Middle, Last)  Wayne David Lee  18. Mother's Name (First, Middle, Maiden Surname)  19b. Mailing Address. (Street and Number or Bural Route Number City or Town				Industry
6 an "n	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	· · · · · · · · · · · · · · · · · · ·		
vithin ene er th	티	9 Homemaker		Housekee	oing
5-C illed v Hygi d oth		17 Father's Name (First, Middle, Last) 18.Mother's Name		,	
121 d be f ental arke	8		Johnson		
MD 21215-0036 d 2 should be filed within 7 lith and Mental Hygiene n 27 is marked other than aumatic event, the Medica	⊢ [	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or R			
MG 2 saum:		Padwa Johnson / Uncle 2016 Northeast Avenue  20a Method of Disposition 20b Place of Disposition (Name of cemetery,	, Baltin	more, Mary.	
of He If ite		1 Burial 2 Cremation 3 Removal from State crematory or other place)	Date	200. Eduation - City o	Town, State
Page Page nent o		4 Donation 5 Other Specify: Cedar Hill Cemetery 07/2	27/2006	Brooklyn P	ark,Maryland
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygene Important: If item 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once	1	21. Signature of Fune and Service Licensee 22. Name and Address of FacilityThe			
	-	4611 Park Hgts. Ave	., Balt	imore, Mar	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or failure. List only one cause on each line. Narcotic and alcohol intoxication	r respiratory arre	st, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease a. Narcotic and alcohol intoxication Death			
		or condition resulting in death)  Due to (or as a consequence of):			
	Sequentially list conditions, if any, leading to immediate bulleto (or as a consequence of):				-
:1.5	έl	cause. Enter Underlying Cause			
	Upsease or injury that initiated  Due to (or as a consequence of):				
cuted		d			
760, ficate be executed g physician and the burial - transit	Medical	XXUNPENDED Item#23a,perME,g860, 10/17/06 TT item#23a,27,28a-f,perME,g858,8/7/06 TT			
760, ficate be g physic the bur	Me	IF FEMALE: 23c. If yes, outcome of pregnancy		23d. Date of deliver	у
68 certifi tding se as	ian	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	ncy	Month	Day Year
Box 68 e death certification the attending ed for use as	past 12 months?    The past 12 months?   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Month   Day				
the d	된	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tol	l bacco use contribute to	the cause of death?
P.C s that	ρ		1 Yes	2 No 3 Pro	bably 4 🗸 Unknown
ds, squire sen signald b	Completed		24a. Was a	n j 24b. Were a	utopsy findings available
aw re has be 2 shc	힐		autops		completion of cause of
Rec The icate	등		1 <b>V</b> Yes 2		es 2 No
tan:	Be (	25. Was case referred to medical examiner?			
With such that the such that t	2	Yes 2 No Inpatient 2 ER/Outpatient 3 DOA One 4 Nursing		Residence 6 🗸 Othe	r: Scene
ing F		28a. Date of Injury (Month, Day, Year)  Natural 5 Position 28a. Date of Injury (Month, Day, Year)  1 Natural 5 Position 1 Yes 2 tr No	28d. Describe h	ow injury occurred	
ttend death ctor: y the	Certification:	Pending Investigation   Fnd 7/20/2006   Fnd 10:12 pm   1 Yes 2 X No	unk		
ivis or A after Dire	ij	3 Suicide 6 XX Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.	or Town, St	tate) 3611 Tibord	ural Route Number, City
Spital Dours filled	Ö	4 Homicide determined (Specify) House or Town, State) 3611 Liberty H			
To th withii To th	Medical	one)  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a and manner stated.			
_	Σ			29d. Date signed (Mo	ontn, Day, Year)
w 0		O.C.M.E.		July 21, 2006	
OK gard		30. Name and address of person who completed cause of death (Item 23a)	004		
Na Y		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	ZUT		
Sta Regist	ate				
Regist	utill.				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** Jűlÿ 2**00**6 Mary Rose Jondo 4:50 A.M /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Baltimore County Gilchrist Center Towson If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Ye Jan 21, Birthplace (State or Foreign Country) 6. Sex 7. Age (In yrs. last birthday) **Funeral** , 1916 Maryland Days Hours 1 M 2 F 213-09-5315 90 Yrs. Director Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits r than "naturel", or Items 23a or 28a-f ehow the Medical Examiner next be notified at ¥Yes 2□No Parkville Maryland Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 3700 East Northern Parkway 21206 United States 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 [Ž]No If Yes, Give Year or Dates: Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status filed within 72 hours after 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 🖾 No Specify: White ۵ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Al Hygiene. Elementary/Secondary (0-12) UNKNOWN College (1-4or 5+) Unknown Seamstress Clothing 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) is marked of Pages 1 and 2 should be Felix Jondo Rachel Patituchy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Jeanette M. Muehleisen (Niece) 676 Yorkshire Drive Edgewood, Maryland, 21040 of Heelth a Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State if It 1 Burial 2 ☐ Cremation 3 ☐ Removal from State tment Oaklawn Cemetery July 26,2006 Baltimore, Maryland injury 4 ☐ Donation 5 ☐ Other (Specify) permit.
Depertrimports
imports
eny inju 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Peaceful Alternatives Funeral & Cremation Ctr. P.A.
2325 York Road Timonium Maryland, 21093 COM 23a. Par1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to infine diate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine The law requires that the death certificate be executed attending physicien and for use as the burial-transit Due to (or as a consequence of): P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4 Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by Division of Vital Records, 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an s certificete has t lirector, page 2 s autopsy 1 Yes 2 No or Attending Physicien: After this certification, funeral director, 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of fnjury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred t Natural 5 Pending nours after death.
neral Director: Aft 1 Yes 2 No investigation 2 Accident 6 ☐ Could not be 3 C Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) determined 4 Homicide To the Hospital o within 24 hours af To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) no pleted cause of deat Item 23a) (Type, Print) 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

2 5 2006

		1	For State Registrar	State of Ma	ryland .		rtment of H			giene Reg. No.	23253
			Decedent's Name (First, Middle, Last,						2. Date of De		3. Time of Death
	Physicia		Rochelle	10	Lins	0~			July 3	3° 2°0	
	/Medić Examin		4a. Fecility Name (If not institution, give	street and number)			4b. City, Town, or	Location of Dea	th J	4c. County of De	ath
	Examin	٠.	Bon Seco	en- Ha	Fige 2	ral	Ba	stemo	-e	N/A	
	Funeral		5. Social Security Number 6. Sec		(In yrs. last	birthday)	If Under 1 Year Months Days	If Under 24 Hrs Hours Min		th 9. B	irthplace (State or Foreign
	Director		216-58-0895	] M 2 💢 F	54	Yrs.	Worth's Days	110013			ARYLAND
	p .	-	Usual Residence of Decedent		10c. City, T	`aa. a. 1 a.					10d. Inside City Limits
	larylan ahow		10a. State 10b. County N/A		Toc. City, 1		IMORE C	ידייע			Y⊟Yes 2⊟No
	8a-f	octo				DALI				40-000-000	
	or 2	Director	10e. Street and Number				10f. Zip Code	20		10g. Citizen of What	
	ath w	rai	1036 COOKS LANI			140.1	212		S	USA	
	er de tems	une	11. Marital Status	12. Was Decedent E Armed Forces?		13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? ( in, Mexican, Pue	to Rican, etc.)	Black, Wi	nerican Indian, nite, etc.
36	s afte	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	1 □ Yes 24□ N If Yes, Give Year or Dates:	0	1	☐Yes 2XNo	Specify:		Specify: B	LACK
8	hour tural	ba	15. Decedent's Edu		1	l6a. Deced	lent's Usual Occupa	ation		16b. Kind of Busines	ss/Industry
5	n 72 i "na ladic	Completed	(Specify only highest grad	e completed)		(Give	kind of work done of OO NOT use retired	during most of wo	orking		,
7	withi ene. than	Ē	Elementary/Secondary (0-12)	College (1-4or 5	+)		CIAL WOR			MEDICAL	
5	filled Hygi other ent, I	Ö	17. Father's Name (First, Middle, Last)					18. Mother's Na	me (First, Middle	, Maiden Sumame)	
an	ould be filed within 72 hours after death with the Maryland Mental Hyglene. arked other than "natural", or Items 23a or 28a-f ahow atic event, the Medical Examinat must be notified at	To B	ALBERT TRAVERS	3				PEAR	L EVANS	3	
Maryland 21215-0036	s 1 and 2 should be filed within 72 hours after death with the Maryla I Health and Mental Hygiene Item 27 Is marked other than "natural", or Items 23a or 28a-f ahov other traumatic event, its Medical Examinations in colling at	-	19a. Informant's Name/Relationship (T)	rpe, Print)		19b. Mailin	g Address (Street a	and Number or F	lural Route Numb	er, City or Town, State	, Zip Code)
Š	and 2 Balth a m 27 ls	1	DOREATHA RICE /	SISTER		1131	WEDGEW	OOD RD	, BALTI	MORE, MD	21229
ē,	ges 1 and 3 of Health If item 27 or other tr		20a. Method of Disposition		20b. Plac	e of Dispo	sition (Name of natory or other place		Date	20c. Location - City	
on O	0 0		1 Burial 2 □ Cremation 3 □ P  4 □ Donation 5 □ Other (Specify)		I	-	M PARK		29/06	WINDSOR	MILL, MD
Baltimore,	permit. Pag Department Important: I any injury o	li	21. Signature of Puneral Service Licens	-	1	22	. Name and Addres	ss of Facility H	OWELL F	UNERAL H	OME 21207
<u> </u>	205 2		[[ ]whyre	O. Water	1						IMORE, MD
			23a. Part. Enter the disease, or comp shock, or hear failure. List only of	lications that caused ne cause on each in	the death.	Do not ent	er the mode of dyin	g, such as cardia	c or respiratory a	rrest,	Approximate Interval Between Onset and Death
1	Physician		Immediate Cause (Final disease or condition	PNR	work	MG					Onder and Death
	/Medical		resulting in death)	Due to (or as	a consequer	nce of):					
	Examiner			b							
	od sit	ine	if any, leading to immediate cause. Enter Underlying Cause, Cliseas a ringuy that initiated events	Due to (or as a	a consequer	nce of):					
	and trans	Examiner	that initiated events resulting in death) Last	c Due to (or as a	- consequer	ace of):					
8760,	requires that the death certificate be executed een signed by the attending physician and nould be detached for use as the burial-transit			220 10 (01 43 1		100 017.					
87	physi the t	dicai		d							
9 x	certific	Physician/Me	IF FEMALE:	23c. If yes, outcome	of pregnanc	v				23d. Date of o	delivery
Вох	eath certif attending for use as	ian	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal de	eath 3	Ectopic pregnancy Other (specify)	,		Month Month	Day Year
o.	the de	ysic	1 ☐ Yes 2VINo 9 ☐ Unknown	9 Unknown	timo or dout						
Ω.	s that the dended by the detached		Part II. Dthersignificant conditions co	ntributing to death bi	ut not resulti	ng in the u	nderlying cause giv	en in Part I.	23e. Did	tobacco use contribute	to the cause of death?
Records,	sign d be	d by	Colon cano	21					10	Yes 2 1 10 3 □	Probably 4 Unknown
0	w requir been si should	ompleted	malnutated						24a. Was	an 24h Were	autopsy findings available
3e	e la has	ш	1. 1. Ciamoli ind						auto	psy prior to primed? death	o completion of cause of
B		O							1 Yes	2 No 1 Y	es 20 No
Vital	Physician: this certific ral director,	o Be	25. Was case referred to medical examiner?	Hospital:			nt 3 DOA Oth	O.C.	eath (Check only	one) idence 6 □Other (S	
of		$\vdash$	1 ☐ Yes 2 No 27. Manner of Death	28a. Dite of Inju	y 21	8b. Time of	IL 3 DOX	4   Indising	_	how injury occurred	becity)
no	Attending I r death. ector: After by the funer	tion	1 Natural 5 ☐ Pending	(Month, Day	y Year)	Injury	Wor	k? Yes 2 ⊟No			
S	death. ctor: A y the fu	fica	3 Suicide 6 Could not be	28e. Place of Inju	Jry - At hom	e, farm, str	eet, factory, office			Street and Number or	Rural Route Number,
Division	- 0	Certification:	4  Homicide	building, etc	c. (Specify)		•		City or To	wn, State)	
_	To the Hospital or Attent within 24 hours after death Yo the Funeral Director: completely filled in by the		29a. Certifier 1 Certifying Phy	sicien: To the best	of my knowle	edge, deat	n occurred at the tir	ne, date and plac	ce, and due to the	cause(s) and manner	as stated.
	To the Hos within 24 h	edical	(Check only one) Medical Exem	iner: On the basis of and manner sta	examination	n and/or in	vestigation, in my o	pinion, death occ	curred at the time,	date and place, and c	lue to the cause(s)
	o thi o thi	Me	29b. Signature and title of certifier	. ^			29c. Licens	e number		29d. Date signed (Mo	nnth, Day, Year)
	7		Darmo	Acml-	ma		Da	3720	3	hul a:	3 2006
	Q,		30. Name and address of person who d	completed cause of d	eath (Item 2	3a) (Type.	Print) A		_	2	,
	0		Terove LAM	3mD 6	300 B	W	Balt	more S	it 130	ictimae 1	56616 an
	St	ate	31. Date filed (Month, Day, Year)								
18	Regist		JUL 2 5 200	16 Maries	ar's Signatui	90	arti)				

		-	For State Registrar	State of M	aryland / Dep <i>Ce</i>	artment of F			giene Reg. No.	06	232	54
- 5	Physicia		1. Decedent's Name (First, Middle, La.	st)				2. Date of Dea Month	Day	Year	3. Time of D	
	/Medic			hason		45 City Town	-1	-	21	0 G	9:45	PM
	Examin	er	4a. Facility Name (If not institution, giv		nospt2		r Location of Deat	n	4c. Count	y of Death	٨	
	Cinnel	,32)	Social Security Number 6. S		e (In yrs. last birthday	If Under 1 Year			th		<u> </u>	Foreian
	Funeral Director			□M 2 <b>⊠</b> F	73 Yrs.	Months Days	Hours Min.	(Month, Da	v. Year)	Count	ace (State or try)	· · · · · · · · · · · · ·
	פ		Usual Residence of Decedent						100			
	arylar show		10a. State 10b. County		10c. City, Town or L					10	od. Inside City	
	Ba-f e	ct	A/M DM		Baltimor						1 🔼 Yes	2   NO
	vith th	Director	10e. Street and Number			10f. Zip Code			10g. Citizen of	What Count	try?	
	s 23s	ra		ette Ave	Service 11.0	3131	lii Orinio 2 / S		USA	ice - America	an Indian	
	Item Item	Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 🔀	No.	Was Decedent of H If Yes, specify Cuba	an, Mexican, Puer	to Rican, etc.)	Bla	ack, White, e		
336	Ir, or	by	3 ☐ Widowed 4 ☒ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🗵 No	Specify:		Speci	Blac	Ł	
5-0036	72 hours after death with the Maryland naturel; or tems 23a or 28a-f ehow iseal Exana ar must be notified at	ted	15. Decedent's E		16a. Dec	edent's Usual Occup	pation	duna	16b. Kind of B			
215	thin 7	ple.	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or	lite.	DO NOT use retired	during most or wo d)	rking				
2121	filed within Hygiene. Ither than	Completed	4th Grade	N A	Hon	remaker			Dome			
pu	be fill	Be	17. Father's Name (First, Middle, Last					me (First, Middle,		,		
Z	should be and Mental is marked of aumatic eve	2	Norman Walat		105 14-	· • 44 (64	Ethel		chinno		0-11	
Maryland	d 2 st th and 7 is n traun		19a. Informant's Name/Relationship (	( ) = 1	A 10-20-00	ing Address (Street			No. of the con-	- C C		
	ges 1 and 2 should be filed within 72 hours after death with the Marylan it of Health and Mental Hygiene. If Item 27 is marked other than "naturel; or liems 23a or 28a-f show there is marked other than the natified at or other traumatic event, it a Mudical Exam as must be notified at		Cherie Johnson 20a. Method of Disposition	daughte	20b. Place of Disc	Clifton An osition (Name of		Date Collin	oc. Location		DA3 wn, State	
altimore,	Pages nent of I int: if its iry or o		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special		Marian mariana	ematory or other plac		beer	-			
Ħ			21. Signature of Funeral Service Lice		New Cod	2. Name and Addre	ss of Facility	1/2006	1501+in	iore, n	MD.	
Ba	permit. Departr Importa any in		Vaudin C.	530000	2	2. Name and Addre	recene Fu	repaison		0261		
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause	d the death. Do not er						Approximate Interval Betw	
	Physician		Immediate Cause (Final disease or condition	Seve.							Onset and D	eath
	/Medical		resulting in death)	a	a consequence of):							
兴	Examiner		Sequentially list conditions	b. Intra	1 Juniohar	abscess						
7	p is	lue	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury		a consequence of):	0	_					
٧	and I-tran	Examiner	that initiated events resulting in death) Last	C	a consequence of):	rend	Concer					
8760,	The law requires that the death certificate be executed the has been signed by the attending physician and orge 2 should be detached for use as the burial-transit											
687	ficate phys s the	oppa		d								
Box (	eath certific attending p	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome					23d. D	ate of delive	rv	
	death e atte	icla	in the past 12 months?	4□Pregnant a		□Ectopic pregnancy □ Other (s <i>pecify)</i> _	у		М	lonth	Day Y	ear
P.0	that the de led by the s detached t	hys	9 Unknown	9 Unknown			<u> </u>					
	res tha igned l be det	<b>Бу</b> Р	Part II. Other significent conditions	contributing to death I	but not resulting in the	underlying cause giv	en in Part I.	23e. Did t	obacco use cor	ntribute to th	e cause of de	ath?
Records,	w require been si should I	ted						10	Yes 2 No	3 🗌 Proba	ably 4 🖸 U	nknown
ecc	law ras be	Completed						24a. Was	psy	prior to con	osy findings a	variable use of
<u> </u>		5						perfo	ormed? 2 No	death?	2 No	
Vital	ician Sertifi ector	Be	25. Was case referred to medical examiner?	Hospital:		0.1		ath (Check only o	on <i>e)</i>			
of	Phyaician: this certific ral director,	To	1 Yes 2 No	1 2 Inpati		SIL SU DON		dome 5 Resident			")	
on	ding h. After fune	tion	1 Natural 5 ☐ Pending	(Month, Da	ay Year) Injury	Wor	rk? Yes 2 □ No	20d. Describe	now injury occu	1160		
Division	Attending r death.	fica	3 Suicide 6 Could not be	e 28e. Place of In	njury - At home, farm, s			28f. Location (	Street and Num	iber or Rura	l Route Numb	
	after Dire	Certification:	4 Homicide	building, e	tc. (Specify)	,		City or To	wn, State)			
	Hospital 24 hours a Funeral		29a. Certifier 1 Certifying P	ysicien: To the bes	t of my knowledge, dea	th occurred at the tie	me, date and place	e, and due to the	cause(s) and m	nanner as st	ated.	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Medical	(Check only 2 Medical Exe	and manner s	of examination and/or tated.	nvestigation, in my o	opinion, death occ	urred at the time,	date and place	, and due to	the cause(s)	
	To t with To t	Σ	29b. Signature and title of certifier			29c. Licens			29d. Date sign		Day, Year)	
•			, _	elle u Dias	V i	Re	2000		+12	1/06		
_	10		30. Name and address of person who Gel areh Ala	VI, MD	5601 CO	on Print) Rave	nBoule	vard, E	altie	n ore ,	MD 212	39
1	Sta Regist		31. Date filed (Month, Day, Year)	006 32/Begist	trar's Signature	raile		(		,		

Betty JUNISON

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death July 22, 2006 8:25 A. M Anna M. Jones 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Stella Maris Hospice Timonium Baltimore 8. Date of Birth (Month, Day, Yea October 14, If Under 1 Year If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Mary Tand Months Days Hours Min 1 M 2 XF 93 Yrs. 214-05-3571 Usual Residence of Decedent 10a State 10b County 10c. City. Town or Location 10d. Inside City Limits Mary land Harford Forest Hill 1 ☐ Yes 2X No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21050 1 Colgate Drive USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 1 Never Married 2 Married 1 ☐ Yes 2 No Specify. Specify: White 3 Nidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0·12) College (1-4or 5+) Accountant Tailoring 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Frank Tuma Rose Koutnik 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William Jones/Son 6512 Lewis Road Baldwin Maryland 21013 20a. Method of Disposition 20b. Place of Disposition (Name of 20c. Location - City or Town, State Most Holy Redeemer 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 7/26/06 Baltimore Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee lton histera 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat disease or condition resulting in death) METASTATIC COLON CANCER Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): that initiated events resulting in death) Last Due to (or as a consequence of): IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? art II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No autopsy performed? Yes 2X No 1 🗌 Yes . Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred . Manner of Death

Physician /Medical Examiner physicien and s the burial-transit

**Physician** 

/Medical

Examiner

**Funeral** 

Director

r then "natural", or iteme 23s or 28s-f ehow the Medical Exeminer must be notified at

filed within 72 hours after death

at Hygiene.

Pages 1 and 2 should be '

permit. Pages 1 and 2 s Depertment of Health ar important: if item 27 ie eny injury or other treu once.

21215-0036

Baltimore, Maryland

2006

Completed by Funeral Director

Be

The law requires that the death certificate be executed signed by the a After thi

Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: o Division within 24 hours efter death.

To the Funerel Director: Al
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To Be	25
	27

Certification 1 X Natural 2 Accident 3 Suicide

4 | Homicide 29a. Certifier

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier

🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

investigation 6 ☐ Could not be

5 Pending

28b. Time of

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily)

28c. Injury at Work? 1 TYes 2 No

29c. License number

TIMONIUM, MD 21093

29d. Date signed (Month, Day, Year)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

DR. TARIQ MAHMOOD 31. Date filed (Month, Da

32 Registrar's Signature

2300 DULANEY VALLEY RD.

State Registra

			For State Registrar	State of Ma	aryland	-	tment of I		l Mental Hy	giene Reg. No.	2006	23256	
			1. Decedent's Name (First, Middle,	Last)					2. Date of De	eath Day	Year	3. Time of Death	
	Physicia /Medic		Greta	May			Krai	ner	July -	20,	2006	7.4017 M	
	Examin		4a. Facility Name (If not institution,	give street and number)	100	0	4b. City, Town,	or Location of De	ath	4c. (	County of Death	. p 0.	
			Baltimore VI	hshington	0 1/1-	(di) (N)	centr	51	m Bur	カノイ	Mn.	no promoto	
	Funeral		5. Social Security Number 215–28–5749	6. Sex 7. Age		st birthday) Yrs.	If Under 1 Year Months Days		n. (Month, Da	ay, Year)		place (State or Foreign	
	Director		Usual Residence of Decedent		73				Aug.	1,193	Z Mai	ryland	
	yland Iow		10a. State 10b. County		10c. City	Town or Loca	ition					10d. Inside City Limits	
	Man Iffed	tor	Maryland Anne	Arundel	Br	ook1yn	Park					1 ☐ Yes 2 ☐ NO	
	within 72 hours after death with the Maryland ene. then "naturel", or items 23s or 28s-f ehow ha Madical Examiner must be notified at	Director	10e. Street and Number				10f. Zip Code			10g. Citiz	en of What Cou	ntry?	
	ith wi	ai	315 Camrose Ave				2122	25			U.S.A.		
	after dea or itema	Funerai	11. Marital Status	12. Was Decedent I Armed Forces?		13. Wa	as Decedent of Yes, specify Cub	Hispanic Origin? san, Mexican, Pu	(Specify Yes or No erto Rican, etc.)	D- 1	<ol> <li>Race - Americ Black, White,</li> </ol>		
36	s afte	y F	1 Never Married 2 Married 3 Widowed 4 Divorced	ld 1 ☐ Yes 2 ☑ ↑ If Yes, Give Year or Dates:	90	10	Yes 2 No	Specify:			Specify: TI	• .	
8	72 hours "naturel", noicel Exc	Completed by	15. Decedent's			16a Decede	nt's Usual Occu	nation		16b. Kin	WI nd of Business/In	nite	
5.	n na	piet	(Specify only highest	grade completed)		(Give kı life, DC	nd of work done NOT use retire	during most of word)	vorking			,	
212	d within piene. r than the Mi	E	Elementary/Secondary (0-12)	College (1-4or 5	)+)	I	lousewi	Ee .		0	wn Home		
Þ	al Hygid other	BeC	17. Father's Name (First, Middle, L.	ast)				18. Mother's N	lame (First, Middle	, Maiden :	Sumame)		
<u>la</u>	should be nd Mental marked o	To	Karl		A	brahams	sen	Eldis	e			Gay	
Maryland 21215-0036	12 should be filed v h and Mental Hygie 7 Is marked other t reumatic event, In		19a. Informant's Name/Relationshi						Rural Route Numb	•			
2	as 1 and 2 of Heelth a litem 27 li		Jacob Kramer (H	lusband)	OOL DI			Ave Bro	oklyn Pai		_		
Baltimore,	Pages 1 and 2 should be filed within lent of Heelth and Mental Hygiene. nt: if Item 27 Is marked other than try or other treumatic event, the Me		20a. Method of Disposition 1 ☐ Surial 2 ☐ Cremation	3 Removal from State	Ce	-	tory or other pla	· 1	Date	20c. Loc	cation - City or To	own, State	
Ë	tmen tant: jury		4 Donation 5 Other (Sp.		Ce			ery 7/				ark Maryland	
Bal	permit. Page Department of Important: If eny injury or		21. Signature of Funeral Service L	icensee		Mig	CuII y	olyniak	Funeral	Home	, P.A.	yland 21225	
			23a. Part 1 Enter the disease, or o		ore, Mar	Approximate							
			shock, or heart failure. List o Immediate Cause (Final	nly one cause on each lin	ne.	10.100	DWN	7			1	Interval Between Onset and Death	
	Physician /Medical		disease or condition resulting in death)  a										
5	Examiner												
9	7	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury										
اغ	and I-transi	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	с									
58			resulting in death) cast	Due to (or as	a consequ	ence of):							
2 C 8	ate hys	Physician/Medicai		d									
×	ath certific ttending p or use as f	/Me	IF FEMALE:	23c. If yes, outcome	of pregnar	icv				2	3d. Date of delive	on.	
Bo	eath etten for u	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal	death 3□E	ctopic pregnand	у			Month Month	Day Year	
20	t the deby the tached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown			., ,, -						
- a	The law requires that the death certificate has been signed by the ettending page 2 should be detached for use as	by P	Part II. Other significant condition	s contributing to death b	ut not resu	iting in the und	erlying cause g	ven in Part I.	23e. Did	tobacco us	se contribute to t	he cause of death?	
9 E	w require been sig should b	ed t							1 🗆	Yes 2	No 3□Prot	bably 4 □Unknown	
<b>∑</b> 00	awre ssber 2 sho	Completed							24a. Was		24b. Were auto	opsy findings available ompletion of cause of	
5 E		Ĕ								ormed?	death?	1	
ita	ysician: ' is certifice director, p	Be	25. Was case referred to medical examiner?					26. Place of D	eath (Check only	-			
>	hysic this ce	ဥ	1 ☐ Yes 2 ☐ No	1.4		R/Outpatient	3 DOA		Home 5□Res			٢)	
Ę.	ding Ph h. After th funeral	on:	27. Manner of Death t ☐ Natural 5 ☐ Pending	28a. Date of Inju (Month, Dat	ry y Year)	28b. Time of Injury	28c. Inju		28d. Describe	how injury	occurred		
Sio	Attendi death. ctor: A y the fu	icat	2 Accident investigation of Could not could no	ot be One Bless of Init	una At ho	no form street		Yes 2 No	28f Location	(Stead and	A Numbas as Pus	al Route Number,	
) Division of Vital	or A	Certification:	4 ☐ Homicide determin	building, et	c. (Specify	)	st, ractory, onice			wn, State)		II Addie Nomber,	
_	To the Hospital or Attending Physician: within 24 hours effor death. To the Funerel Director: After this certifica completely filled in by the funeral director, t	aic	29a. Certifier To Certifying	Physician: To the best	of my knov	viedge, death o	occurred at the t	ime, date and pla	ice, and due to the	cause(s)	and manner as s	atated.	
	Ho Ho	edical	(Check only 2 Medical E	xaminer: On the basis of and manner sta	f examinat	on and/or inve	stigation, in my	opinion, death oc	curred at the time	date and	place, and due to	o the cause(s)	
	To th Withir To th Comp	ž	29b. Signature and title of certifier		_		29c. Licen	se number		29d. D. te	a signed ( onth,	Day, Year)	
			1-80	× / V	n D		DH	8006	(	071	2012	006	
	K		30. Name and address of person w	who comilleted cause of d	leath (Item	23a) (Type, P	rint)	1 1)	(-1	کم د	12	11	
-	.,/		KOT) SON	32 Registr	50	1 - 17	Dust.	s' DV	1 1	V)	Byrn	17) 11)	
	Sta Registr		31. Date filed (Month, Day, Year)	2005 A SA	ar a signa	A STATE OF THE STA	SEL S						

			For State Registrar	State of Ma	-	-	nent of H		Mental H	ygiene	106	23257
			Decedent's Name (First, Middle, Last)		· · · · · · · · · · · · · · · · · · ·				2. Date of D		Year	3. Time of Death
	Physici /Medio		Dorothy	Vir	ginia	F	Kess-J	acksor		21, 2	1006	11:34 P M
	Examin	er	4a. Placility Name (If not institution, give the Cary and Ger	reral Ho:	spital	P	altin	Location of De	ity		ty of Death	
	Funeral Director		5. Social Seculity Number 6. Sec 212-22-5872	1 477 -	e (Mi yrs. last birtl 88 Y		Inder 1 Year oths Days	If Under 24 H Hours Mi		Jay, Year 17	9. Birthp	place (State or Foreign MD
			Usual Residence of Decedent									
	ehow	_	10a. State 10b. County		10c. City, Town						1	0d. Inside City Limits Yes 2 □ No
	the Ma 28a-f	Director	MD NA  10e, Street and Number		Balt					10g. Citizen of	What Cour	
	€ 9	i i		7 ***		10	rf. Zip Code 212	207		_	S.A.	itr <b>y</b> r
~	death w	Funeral	5301 Fern Park  11. Marital Status	12. Was Decedent E	Ever in U.S.	13. Was E			(Specify Yes or Nerto Rican, etc.)		ce - Americ	
2 9	or ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ X If Yes, Give	No		, specify Cuba es 2. ∑No	n, Mexican, Pui Specify:	erto Hican, etc.)		ack, White,	
) 003	hours after tural', or ite al Examina	d by	3X Widowed 4 □ Divorced	Year of Dates:						Speci	, Б.	lack
15-	within 72 h ane. than "natu	iete	15. Decedent's Edu (Specify only highest grad	cation e <i>completed)</i>	16a.	(Give kind o	Usual Occupa of work done o OT use retired	furing most of w	vorking	16b. Kind of B	3usiness/Inc	dustry
1C,		Completed	llth grade	College (1-4or 5 na	i+)		t Wrap			Depar	tment	t Store
100	be filed tal Hygi d other	Bec	17. Father's Name (First, Middle, Last)					18. Mother's N	ame (First, Midd	e, Maiden Surna	me)	
\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\			William Kess					Clare	Smith			
/ar	2 sh and ie m		19a. Informant's Name/Relationship (Ty		1	1100			Rural Route Num			
e, 1	1 and 2 Health tem 27 i		Gwendolyn Berry 20a. Method of Disposition	y-Daught	20b. Place of	Disposition	(Name of		Date Bal	20c. Location	-	21239 own, State
Ton	age: ant o nt: if		1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	lemoval from State	Arbut		y`or other plac ⊃moria		27/06	Arbut		
	그 돈 돈 글	3	21. Samura Funeral Service Licens	90 ~/	Intode	22. Nam	ne and Addres	s of Facility	27,00		45, 1	10
	Dermi Depa Impo eny it	( ()	> xonaia C	, Juga	U	4300	O Waba	I West ash Av	e, Balt	imore,	Md	21215
			23a. Parth. Enter the disease, or compl shock, or heart failure. List only or	ications that caused ne cause on each lin	the death. Do n	ot enter the	mode of dyin	g, such as card	iac or respiratory	arrest,		Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition regulting in death)	Septil	shoc	'K						Onset and Death
	/Medical Examiner		resoluting in dealth)	Due to (or as	a consequence o	hol	: 00	idos	: (			
		er	Saquentially flet conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	ue to (or as	a consequence of	of):		1				
	outed id ansit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	metasta	tic live	~di&	ease w	ith inte	stinal pr	iman/Co	mar	
,0	e exec ien ar urial-ti		resulting in death) Last	Due to (or as	a consequence o	of):				7		
8760,	cate be executed physicien and the burial-transit	dical		d								
Box 6	n certific anding p use as	/Me	IF FEMALE:	3c. If yes, outcome	of pregnancy	355				334 D	ate of delive	201
B	death atten	cian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death		pic pregnancy er (specify)				lonth	Day Year
0.	that the de ed by the detached	hysi	9 Unknown	9□ Unknown								
Division of Vital Records, P.O.	ires tha signed I s be det	Completed by Physician/Med	Part II. Other significant conditions con	ntributing to death be	ut not resulting in	the underly	ring cause give	on in Part I.		tobacco use cor	ntribute to th	ne cause of death?
Sor	w requir been si should	letec							24a. We			
Re	The lav	duc				<del></del> _			- aut	opsy formed?	prior to cor death?	psy findings available mpletion of cause of
ital	ician: Th certificete ector, pag	0	25. Was case referred to medical					26. Place of D	eath (Check only	2 PNo	1 🗆 Yes	2 No
,	hysician: this certific el director,	To B	examiner? 1 □ Yes 2 <b>1</b> No	lospital: 1 [Vinpatie		tpatient 3[	□ DOA Othe	9C 4 ☐ Nursing	Home 5□Re	sidence 6 □Ot	her (Specif	y)
n o	ding Ph. After th funerel	uo.	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	ry Yea <i>r)</i> 28b. T	njury	28c. Injury Work		28d. Describe	how injury occu	rred	
isic	death death ctor: y the f	licat	2 Accident investigation 3 Suicide 6 Could not be	28e Place of Inju	ury - At home, far	m street fa		Yes 2 □No	28f. Location	(Street and Num	ber or Burs	J Route Number
Div	after after i Dire	Certification:	4 Homicide determined	building, etc	c. (Specify)	, , , , , , , , , , , , , , , , , , , ,	actory, office			own, State)	our or ribra	TOUTO NUMBER
	To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending physician and completely filled in by the funerel director, page 2 should be detached for use as the burial-transit	edical C	29a. Certifier 1 Certifying Phy. (Check only one)	sician: To the best of ner: On the basis of and manner sta	examination and	, death occu d/or investig	urred at the timation, in my op	e, date and pla pinion, death oc	ce, and due to the	e cause(s) and m e, date and place	nanner as si	lated. the cause(s)
_	To the Hos within 24 h To the Fun completely	Me	29b. Signature and title of certifier				29c. License	number	0 -	29d. Date sign	ed (Month,	Day, Year)
			> Sqid Araw					0	2506	July	21	200Co
	2 1		30. Name and address of person who co	ompleted cause of d	eathy(Item 23a)	ype, Print)	laind	Com	0///	2001	1/	<u></u>
)	/		31. Date filed (Month, Day, Year)	Me De C	ar's Signature	ary	juriu	Gene	ray He	15p11a	/	
	Sta Registi		1111 2.5 2006	See See	ar's Sienature	Carried States	r			•		

			For 1_ State	State of Marylan	-			ental Hygie	ne	00050
			Registrar		Ceni	ficate of De		Rag.	No.	3. Time of Death
	Physici	an	1. Decedent's Name (First, Middle, Last)					2. Date of Death Month	Day Year	1525 M
	/Medic			<1NG		0.5		JULY	4c. County of Death	1043 **
	Examin	er	4a. Facility Name (If not institution, give :	0 1	1 -11	b. City, Town, or Loc	ation of Death		11	100
-	·		5. Social Security Number 6. Sec		last hirthday)	If Under 1 Year   If	Under 24 Hrs.	8. Date of Birth	HOWER O	
	Funeral Director			M 2□F 7~			ours Min.	(Month, Day, Ye	18134 Blade	place (State or Foreign ntry)  CO. NC
			Usual Residence of Decedent					13/18/	17137 0120	ST, LUI TO
	yland		10a. State 10b. County	10c. C	ity, Town or Loca					10d. Inside City Limits
	Mar	to	MD PG		20	wie				1 Yes 2 □ No
	th the	Director	10e. Street and Number	1.		10f. Zip Code	,	10g.	. Citizen of What Cou	ntry?
	th will		15216 Noblew	ood LN		2071	16		U.S.A	
	dea	Funeral	11, Marital Status	12. Was Decedent Ever in L Armed Forces?	J.S. 13. Wa	is Decedent of Hispar es, specify Cuban, M	nic Origin? (Spec lexican, Puerto R	ofy Yes or No- tican, etc.)	14. Race - Amer Black, White	
98	burs after death with the Marylan rei", or items 23a or 28a-1 ehow Exanitrar install by the differd at		1 Never Married 2 Married	1 Nes 2 No /19	.15		pecify:		Specify: Blo	
21215-0036		d by	3 ☑Widowed 4 □ Divorced	ff Yes, Give 33/19 Year or Dates: 35	124/4		-		-	
5	be filed within 72 ho ital Hygiene d other than "natu event, ire Miculia	Completed	15. Decedent's Edu (Specify only highest grad		(Give kir	nt's Usual Occupation and of work done durin ONOT use retired)	g most of workin	g 161	b. Kind of Business/li Health Ca	
12	within lene. than "	m d	Elementary/Secondary (0-12)	Coltege (1-4or 5+)	SuzalVA	Yout Soon:	dist		Industr	
	filed with Hygiene other than went, Ire		17. Father's Name (First, Middle, Last)	0	The state of the s	18.	Mother's Name	(First, Middle, Mai		1
an		To Be	Memphis King			Ť	Tula M	Taxe Por	1.0	
Maryland	Should M	-	19a. Informant's Name/Relationship (Ty	pe, Print)	19b. Mailing	Address (Street and I	Number or Rural	Route Number, C	ity or Town, State, Zi	p Code, UNKNOWN
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ē,	s 1 and the Healt tem 2 other		20a. Method of Disposition	20b.	Place of Disposit	ion (Name of tory or other place)	Da	ite 200	c. Location - City or T	own, State
Ę	Pages ment of ant: If it ury or c		1 ☑ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)		surrect		NO7/22	106 (	Minton.	MD
altimore,	고 본 별 등	1	21. Signature of Funeral Service Licens	90	22. 1	Name and Address of	recility	5732	-eorgia	
ä	Depa Impo any i		James !	(Mari	TP	II-State	e F/S	Washingto	on DC. Zo	0011
			23a. Part1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the dea	th. Do not enter	the mode of dying, su				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	CORONAF	RUNR	TERY :	DISEAS		100	Onset and Death
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н	Examiner		Conventially list appditions	END 5	TAGE	REN	AL	DISEA	BE	years
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9	leath certific attending p	₩.	IF FEMALE:	20 Hugo sutcomo el cross						
Box	ath c	lan/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of pregr	taf death 3□E	ctopic pregnancy			23d. Date of deliver Month	'ery Day Year
o.	the the	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐Pregnant at time of 9☐Unknown	death 5∐C	Other (specify)	1.00			
Δ.	that the		Part II. Other significant conditions con	ntributing to death but not re	sulting in the und	erlying cause given in	Part I.	23e. Did tobac	co use contribute to	the cause of death?
ds,	uires tha signed id be de	d by	GT BREEdIN	19		, ,		1 🗆 Yes	2 No 3 Pro	bably 4 Unknown
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of Vital Records,								1 Yes 2	No 1 ☐ Yes	2□ No
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of	Phys rahis rahdi	7	1 Yes 2 No	28a. Date of Injury	28b. Time of	3□ DOA 28c. Injury at		se 5 ∐ Residenc 8d. Describe how	e 6 Other (Specinium occurred	(y)
on	ding h. Alte fune	tion	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury	Work?	2 □No		, ,	
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ă	after after Dire	Certification:	4 Homicide determined	building, etc. (Spec	cify)			City or Town, S	State)	
	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		29a. Certifier 1 Certifying Phy	sician: To the best of my kr	nowledge, death of	occurred at the time, d	late and place, a	nd due to the caus	se(s) and manner as	stated.
	n 24 n 24 he Fu	Medical	(Check only 2 Medical Exami one)	ner: On the basis of examinand manner stated.	nation and/or inve	stigation, in my opinio	on, death occurre	d at the time, date	and place, and due	to the cause(s)
	To t To t	Σ	29b. Signature and title of certifier			29c. License nu	mber	29d.	. Date signed (Month	Day, Year)
	4		Suple	ND		3000	5315	DI	ULY 170	n 2006
	'		30. Name and address of person who co		em 23a) (Type, Pr	int)			Seit	110
	1		shakun		SUPE	965	0 200	mago	Koad	columbic
	Sta Regist		31. Date filed (Month, Day, Year)	32. Registrar's Sign	L	. the				4043
	4 3		1111 0 5 200	F-170 A	IT. ILAM	ANT I				

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene 🗍 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician -EL01 01-15.2006 10:30 /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner COUMBIA

If Under 1 Year

Months Days Hours Min.

Min.

(Month, Day, Year)

(7. 05. 1940) HOWARD 5418 CEDAR LANE . Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1**⊠**M 2□F 216.36.4653 Yrs MD Director lob Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State item 27 is marked other then "natural", or items 23s or 28e-f show other traumatic event, the Madical Examinar must be mailfied at 1 Yes 2 No Director COLUMBIA MD HOWARD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 5418 CEDAR LANE # B2 USA 21044 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after I ☐ Yes 2 KNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: þ BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) BUREAU FOREMAN WATER 8 1H GRADE NA 18. Mother's Name (First, Middle, Maiden Surname) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if item 27 is marked other my injury or other traumatic event. 17. Father's Name (First, Middle, Last) LEE DANIEL DORSEY DORA LEE SCOTT 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) #B2, COLUMBIA, MD WIFE 5418 CEDAR LANE SERREACE KELLY 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 01.22.06 ELKRIDGE , MD 4 □Donation 5 □ Other (Specify) MEADOWRIDGE 22. Name and Address of Facility VAUGHN C. GREENE FUNERAL SERVICE 5151 BAUD. NATE PIKE, BAUD. MO 21229 21. Signature of Funeral Service Licensee Vanghr 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) mitastatic **Physician** Melanona 6 weeks /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No Month Year 4 Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 9 Unknown Part II, Dther significant conditions contributing to death but not resulting in the underlying gause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ from mylanine Stomalh correst 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed 1 Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Aesidence 6 Other (Specify) 1 ☐ Yes 2 No 28b. Time of 27. Manner of Death

1 Natural
2 Accident 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: ai or Attending P safter death. i Director: Aftar t d in by the funera Aftar 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 Could not be determined 3 Suicide 28f Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide To the Hospital o within 24 hours aft To the Funeral Di 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier D 30573 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 11065 Little Paturent Pluy Columbia Md. 21044 MD 31. Date filed (Month) 32 Registrar's Signature State Registrar

			1 - For Amend item#31,	State of Ma perDVR,g857,7	ryland / [ /25/06 TI	epa Cert	rtment of H tificate of L	ealth and N D <i>eath</i>	Mental H	ygien Rag. N	1e205	23260
			Decedent's Name (First, Middle, La	st)					2. Date of D		\a \V	3. Time of Death
	Physicia		Honore K. Kea	ne					July		2006 Year	1:32 P M
	/Medic Examin		4a. Fecility Name (If not institution, giv	e street and number)			4b. City, Town, or	Location of Death	<u></u>	4	c. County of Death	1
	Examin	٠.	Suburban Hospit	a1			Bethes	da			Montgom	nery
	Funeral		5. Social Security Number 6. S	Sex 7. Age	(In yrs. last bir	thday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of B	irth	9. Birth	place (State or Foreign
	Director		577-40-8629	□M 2X1F	75	Yrs.	Month's Days	TIOUIS ININI.	Feb. 2	6,	1931 West	Virginia
	P .		Usuel Residence of Decedent		40. C'. T							404 Invite Ob. Limbs
	how	_	10a. State 10b. County		10c. City, Town		ation					10d. Inside City Limits 1 ☐ Yes 2 No
	8a-f	Funeral Director	Maryland Montgome	ery	Bethes	sda						
	or 2	ä	10e. Street and Number				10f. Zip Code				Citizen of What Cou	
	8th w	-a	6904 River Road	· · · · · · · · · · · · · · · · · · ·			20817				ited Stat	
	tem de	The	11. Marital Status	12. Was Decedent B Armed Forces? 1 ☐ Yes 2 \ \ \	ever in U.S.	13. W	as Decedent of Hi Yes, specify Cuba	spanic Origin? (Sp n, Mexican, Puerto	pecify Yes or No Rican, etc.)	10-	14. Race - Amer Black, White	
36	or i	by F	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	If Yes, Give	lo	1	☐ Yes 2Ã No	Specify:			Specify:Whi	te
21215-0036	hour	호	15. Decedent's E	Year or Dates:	162	Deced	ent's Usual Occupa	tion		16b	Kind of Business/I	ndustry
ည်	n 72	Completed	(Specify only highest gr	ade completed)		(Give k	and of work done of ONOT use retired	furing most of wor	king	100.	Tana or basinesan	riddoli y
12	withing the the	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5		enef	its Coor	dinator		Gi I	llette Re	search
0	Hyg Hyg Sther ant,	ပိ	17. Father's Name (First, Middle, Last	)				18. Mother's Nam	ne (First, Middi			
an	id be ental ked (	To Be	Thomas Acquinas	Keelan				Vada C	leary			
تر	shou mar imat	-	19a. Informant's Name/Relationship (	Type, Print)	19b	. Mailing	Address (Street a	and Number or Ru	ral Route Num	ber, City	y or Town, State, Z	ip Code)
Ĕ	nd 2 lith a 27 le		Thomas T. Keane,	III/son	10	0513	Bridle 1	Lane, Po	tomac,	MD	20854	
ē,	t Heef t Heef Itam othe		20a. Method of Disposition		20b. Place of	f Dispos	ition (Name of atory or other place	e)   T11 T v	Date 22,	20c.	Location - City or 1	Town, State
Ě	Pege ento t: If		1 ☐ Burial 2 ☒ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				Crematoriu			Ве	ethesda,	Marvland
Baltimore, Maryland	permit. Peges 1 end 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 Is marked other then "natural", or Items 23e or 28s-f show any Injury or other traumatic avant, the Medical Examinar trausities incitified at once.		21. Signature of Funeral Service leice		12220		Name and Address					1101/2011
m	Departiment of the population		William a Kon	Show 1	401173	300	O W. Montg	omery Aven	ue, Rock	ville	e, Marylan	1 20850
			23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused	the death. Do	not ente	r the mode of dying	g, such as cardiac	or respiratory	arrest,		Approximate Interval Between
	Physician		Immediate Cause (Final	~	Hip Fra	2 C T 11	ra					Onset and Death
	/Medical		disease or condition resulting in death)	a	a consequence		16					
	Examiner											
		je.	Sequentially list conditions, if any, leading to immediate	Due to (or as	a consequence	of):						
	cuted	Examiner	Cause (Disease or injury that initiated events	С.								
o,	en ar	EX	resulting in death) Last	Due to (or as	a consequence	of):						
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_	ntifica ng ph as th		IF FEMALE:									
Вох	death certil e ettending id for use a	an/h	23b. Was decedent pregnant	23c. If yes, outcome 1 ☐ Live birth		3 □	Ectopic pregnancy				23d. Date of deliv	
	dea ded fo	by Physician/M	in the past 12 months? 1 ☐ Yes 2 Ø No	4☐Pregnant at 9☐ Unknown			Other (specify)				Month	Day Year
P.0	law requires that the as been signed by th 2 should be detache	ج	9 Unknown						1			
	res tha signed be del		Part II. Other significant conditions	contributing to death b	ut not resulting i	ก the แก	derlying cause give	en in Part I.				the cause of death?
2 d	w require been signature should t	ted	Heart Failure						١١	] Yes	2AINo 3 Pro	obably 4 Unknown
Vital Records,	e law r has be	Completed						1	24a. We	s an	24b. Were aut	topsy findings available ompletion of cause of
<u> </u>	The lete hig	PO.			Patri	ad	Toursk	o May m	1□ Yes	formed?		2□ No
ita	sian: artific ctor,	Be (	25. Was case referred to medical examiner?					26. Plage of Dea	th (Check only	one)		
	Physician: this certific ral director,	2	1 No 2 No	Hospital: 1X Inpatie	nt 2□ER/Ou	utpatient		4   Nursing H	ome 5□Re	sidence	6 ☐Other (Spec	ufy)
ם	ng P Mer t Inera		27. Manner of Death 1 □Natural 5 □ Pending	28a. Date of Inju (Month, Da		Time of Injury	28c. Injury Work				jury occurred	
Sio	Attanding r death.	cati	2 Accident investigation 3 Suicide 6 Could not t	July 10,				Yes 2∭No	Fa			
Division of	or Ati	Certification:	4 Homicide determined	building, et	(Specify)	arm, stre	et, factory, office		City or T	own, Sta		
	urs e		00- C-44		ng home							eda, Maryland
	To the Hospitel or Attending Physicien: The within 24 hours elter death.  To the Funeral Director: Atter this certificete ha completely filled in by the funeral director, page	Medical	29a. Certifier 1 ☐ Certifying P (Check out) 2 ☐ Medical Exa	hysician: To the best miner: On the basis of and manner sta	examination ar	e, death nd/or inv	estigation, in my op	ne, date and place pinion, death occu	, and due to the rred at the time	e cause e, date a	(s) and manner as and place, and due	stated. to the cause(s)
	o the ithin i o the	Mec	29b. Signature and title of certifier	Circ mainer ste			29c. Licens	number		29d. C	Date signed (Month	, Day, Year)
	F ¥ F 8		Alina.	( )	71			11906		7.	19.06	
	1		30. Name and address of person who	to serves hetalamon	eath (Item 28a)	(Type 5	Print) A				D =	1
	1		30. Nather and address of person who	3/10/		-( ( - C		Lledge	Bru	e,	Gelher	da MJ
	Sta	te	31. Date-filed (Month, Day, Year)	32. Registr	ar's Signature		120					20 (1)
	Regist		111 957	106 Basia	U K	400	BOLL					
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			For State Registrar	State of Ma	ryland / Depa <i>Cei</i>	artment of H rtificate of I			ne2 0 0 (	23261
			Decedent's Name (First, Middle, Last)					2. Date of Death	Day Yea	3. Time of Death
	Physicia		Thomas Br	uce Lem	merman			July 24		9:02 A M
	/Medic Examin		4a. Facility Name (If not institution, give si			4b. City, Town, or	Location of Death		4c. County of De	ath
			117 Stonewall	Road		Cat	tonsvill	Le	Bal	timore
	Funeral		5. Social Security Number 6. Sex	7. Age	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Y	'ear) (	irthplace (State or Foreign Country)
	Director		214-54-7963	.M 2UF	56 Yrs.			SEP 19,		ryland
	pud *	1	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or Lo	ocation				10d. Inside City Limits
	lanyla eho	ŏ	Maryland Baltimor		•	Cost	on 11 -			1 ☐ Yes 2X No
	the N	Director	10e. Street and Number	.e		10f. Zip Code	onsville	100	. Citizen of What (	Country?
	with be or	₫	117 Stonewall R	Road			228		USA	,
	tiled within 72 hours after death with the Maryland Hygiene. ther than natural; or tama 23a or 28a-f ehow int, the Madical Exammer must be motified a	Funeral		2. Was Decedent E	ver in U.S. 13.	Was Decedent of H	ispanic Origin? (Sp	ecify Yes or No-	14. Race - An	nerican Indian,
<b>'</b> 0	ritar	표	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☑Yes 2 ☐ N	0	If Yes, specify Cuba		Hican, etc.)	Black, Wi	nite, etc.
ဗ္ဗ	urs a		3 ☐ Widowed 4 💆 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2 🛣 No	Specify:		Specify:	White
21215-0036	72 ho	Completed by	15. Decedent's Educ (Specify only highest grade		16a. Dece	dent's Usual Occup	ation during most of work	ina 16	b. Kind of Busines	s/Industry
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7	ed w ygier yer th	ပိ	12			TLUCK DIT		- /Fina Middle Ma	Truckin	ıg
핕	be fill d off	Be	17. Father's Name (First, Middle, Last)					e (First, Middle, Ma		
3	i Mer narke	ြ	John F. Lemmerma	-	10h Maili	- Address /Ctroat		harine M al Route Number, (		Zin Codo)
Maryland	12 st h and 7 te n treun		19a. Informant's Name/Relationship (Typ			•				
e,	1 and Healt em 2 ther		Katharine M. Lemme	erman/Motr	20b. Place of Dispo	Stonewall		atonsville	oc. Location - City	
٥	ages nt of nt of :: # it		1 Burial 2 □ Cremation 3 □ Re	emoval from State	,	matory`or other plac	7/00	100	D 1. 1 33	55 5404
altimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural; or itama 23a or 28a-f show any injury or other treumatic event, the Madical Examiner must be multiled at Once.		4 □Donation 5 □Other (Specify)  21. Signature   Funeral Service License	na /	Loudon Pa	ark Cemet	ery 7/28	:Nabb Fune	Baltimor	e, MD
Ba	permi Depa Impo any i		· Edward 7 12	me				Catonsv		
			23a. Part1. Enter the disease, or complic	gorchik cations that caused	the death. Do not en					Approximate
			shock, or heart failure. List only on Immediate Cause (Final	e cause on soh lin	1125	14111	1			Interval Between Onset and Death
	Pnysician /Medical		disease or condition resulting in death)	Due told as a	MUNG.	wy	T)			
п	Examiner			NU	person	Up				
		ē	S eventially list conditions if any, leading to immediate cause. Enter Underlying	Due to (or as a	consequence of):	- V"				
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oʻ	e exe ien ar urial-t	EX	resulting in death) Last	Due to (or as a	a consequence of):					
8760,	icate be executed physicien and stree burial-transit	dical	d							
9	leath certific attending p	0	IF FEMALE:	- "						
Box	death certifi e attending id for use as	an/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1☐Live birth	2 ☐ Fetal death 3 [	Ectopic pregnancy	,		23d. Date of d Month	lelivery Day Year
	the a	Physician/M	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4☐ Pregnant at 9☐ Unknown	time of death 5 L	Other (specify)				
P.0	that the de led by the a detached t		Part II. Other significant conditions con	tributing to death bu	it not resulting in the u	Inderlying cause giv	en in Part I.	23e. Did toba	cco use contribute	to the cause of death?
Vital Records,	8 <u>5</u> 8	d by				, , ,		1 ☐ Yes	2 □ No 3 □	Probably 4 Unknown
Ö		ete						24a. Was an	24h Were	autopsy findings available
Rec	e la has le 2	Completed						autopsy	prior t death	o completion of cause of ?
<u></u>		e Co	25. Was case referred to medical				OC Diseased Door	1 Yes 2		es 2 No
₹	Physician: this certific ral director,	o Be	evaminer?	lospital:	nt 2 ER/Outpatie	nt 3 DOA Oth	er	th (Check only one) ome 5 Residen		nacifu)
of		-	27. Manner of Death	28a. Date of Injur	y 28b. Time o			28d. Describe how		Jecny)
ion	Attending Indead to death.	ţ	1 Matural 5 Pending 2 Accident investigation	(Month, Day	Year) Injury		Yes 2 □No			
Division	of or Attendation of the death of the country of the country of the formal of the fore	100	3 Suicide 6 Could not be determined	28e. Place of Inju- building, etc	ry - At home, farm, st	reet, factory, office		28f. Location (Stre City or Town,		Rural Route Number,
Ö	s afte s afte si Dir	Certification:	Tiomcos	bullaling, etc	. (Specify)			ony or rount,		
	To the Hospital or At within 24 hours after or To the Funeral Directompletely filled in by		29a. Certifier 1 Certifying Phys	sician: To the best oner: On the basis of	of my knowledge, deat examination and/or in	th occurred at the tir	ne, date and place,	and due to the cau	se(s) and manner e and place, and d	as stated. ue to the cause(s)
	To the H within 24 To the F complete	Medical	one)	and manner sta						
	To Vity	2	29b. Signature and title of certifier	11111111		29c. Licens	La71		d. Date signed (Mo	
7	1.1		1				1. 1 1 1	J	uly 25,	2006
	1071		30. Name and address of Serson				Azonia D-	1+	MD 01000	
	-01		Miguel A. Hered: 31. Date filed (Month, Day, Year)		413 COMMO	niwearth F	avenue Ba	ıtımore,	MD 21228	
9,	Sta Regist چ		JUL 2 5 2006	Stawa	7 4	de la				

06-05377 Paul Loss

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar	Certificat	te of	Death			Reg	. No. 200	06 2326
Physicia	n/	Decedent's Name (First, Middle,Last)					Mon	of Death	Day Year	3. Time of Death
ledical Exami	ner	Paul Forrest L	oss		o. City, Town, or L	o antion o		24, 200	)6 4c. County of Dea	0049 hrs
*		Facility Name (if not institution, give street and number)     Good Samaritan		4	Baltimore	_ocation o	Death			1/A
Funeral		5. Social Security Number 6. Sex 7. Age (	In yrs. last birthd	lay)	If Under 1 Year	If Under	r 24Hrs. 8. Da	te of Birth	(MM/DD/YYYY) 9. I	Birthplace (State or
Director		215-56-5622 1XM 2 F	57	Yrs.	Months Days	Hours		'P 23	, 1948 For	eign Country) Mary1and
	ŀ	Usual Residence of Decedent				L		11 23	, 1740	rial y land
y any		10a State 10b. County 10	c. City, Town or	Locatio	in					10d. Inside City Limits
Aaryland 28a-f show 1 at once.	ē	Maryland Baltimore			Park	ville	9			1 Yes 2 X No
Mary r 28a- ed at	Director	10e Street and Number		l	10f. Zip Code			100	g. Citizen of What Co	ountry?
th the 23a or notifie		7530 Oakleigh Road	Table Ta	10. \\		234	i=2 / C # . V-		USA 14 Bass Am	erican Indian, Black,
15-0036 filed within 72 hours after death with the Maryland I Hygiewell 14 doubter than "natural", or items 23a or 28a-f site, the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 Married 12. Was Decedent Evant Armed Forces?			Decedent of Hisp s, specify Cuban,				White, etc	erican indian, black,
ter de		1 Yes 2 X 3 Widowed 4 Divorced If Yes, Give Year	No	1	Yes 2 X No	specify:			Specify: Wh	ite
ours al	d b	15. Decedent's Education (Specify only highest grade compl	eted) 16a. De	ecedent'	s Usual Occupation	on (Give k	aind of work dor	ne 1	16b. Kind of Busines	s/Industry
6 72 hc rai "m"	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)					use retired)			
5-0036 iled within 72 Hygiene 1 other than	鬞	12		Neve	er Worked		. hl	1.1.1.	N/A	
15-00 filed wit I. Hygien ed other t, the M		17. Father's Name (First, Middle, Last) Paul Forrest Loss			[ ]					
AD 21215-003 2 should be filed with h and Mental Hygiene 27 is marked other ti	o Be	19a. Informant's Name/Relationship (Type, Print )	19b.	Mailing	Address (Street		nry Emma		er, City or Town, Sta	ate, Zip Code)
<b>5</b> 0201	-	Mohanie S. Loss/Wife	7	530	Oakleigh	n Roa	ıd Parl	cvi 11	e. MD 21	234
e, No I and Health item	U	20a. Method of Disposition	20b. Place of	Disposit	ion (Name of cem		Date		20c. Location - City	
Baltimore, I permit Pages I and Department of Heal Important: If item injury or other trai		1 Burial 2 X Cremation 3 Removal from State 4 Donation 5 Other Specify:			atory, I	nc.	7/25/0	6	Baltimore	e, MD
Baltimo permit Page Department ( Important: injury or ott		21. Signature of Funeral Service Licensee		22. Na	ame and Address	of Facility	Crema	tion	Society o	of MD, Inc.
		Edward A. Gregorchik					Road_Ba.	ltimo	ore. MD 21	228 Approximate Interval
Physician /Medical		23a. Part I. Enter the disease, or complications that caused th failure. List only one cause on each line.			e mode of dying, s	such as ca	ardiac or respira	atory arres	st, snock, or neart	Between Onset and Death
xaminer		Immediate Cause (Final disease or condition resulting in death)  a. Obstruction  Due to (or as a consequence)					· · · · · -			Dear
		Sequentially list conditions, b. Swelling of	,	is a	nd vocal c	ords_				
	iner	if any, leading to immediate cause. Enter Underlying Cause C. Allergic r		ef unl	man etio	1000				
	Examiner	(Disease or injury that initiated events resulting in death) Last  C. THICIGITE  Due to (or as a consequence of the consequence		1 (111	GIOMII ECTO	Togy				
cuted and transi		d								
760, icate be executed physician and the burial - trans	/Medical	X UNPENDED X AMENDED item	#1,23a,27	,28a	-f,perME,g	860, 1	10/2/06 T	Τ		
		IF FEMALE: 23b. Was decedent pregnant in the 1 ☐ Live birth		Fet	al death 3	Ectopic	pregnancy		23d. Date of deliv Month	ery Day Year
Box 68: death certificate attending	siciar	past 12 months?		=	er (Specify)		, , ,			· ·
Bo le deat the att	Phys	1 Yes 2 No 9 Unknown g Unknown						- Dida-		1- II II II
P.O. Erres that the designed by the	by F	Part II. Other significant conditions contributing to death be	out not resulting i	in the ur	ideriying cause gi	iven in Pa	n I. 20	Yes		to the cause of death?
IS, F quires en sig uld be						-	1 24	a. Was ar		autopsy findings available
Division of Vital Records, tal or Attending Physician: The law requin star death.  In Director: After this certificate has been sited in by the funeral director, page 2 should t	Completed	<u> </u>					<del></del>	autopsy	y prior t	o completion of cause of
tal Rec	S				00 81	-(Death		Yes 2	No 1 <b>✓</b>	Yes 2 No
ital   sician: s certifi irector,	Be	25. Was case referred to medical examiner?	2 FR/Out	natient		Other	(Check only one Nursing Home	-	tesidence 6 Ot	ner:
t of Ving Phys After this	. To	27. Manner of Death 28a, Date of Injury	28b. Ti	me of In		y at Work			w injury occurred	
on tending eath.	tion	1 Natural 5 Pending (Month, Day, Yea	uk		1_ Y	'es 2	No uk			uk
ViSi or Att fter de Directe	ifica	2 X Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injur		m, stree	t, factory, office bu	uilding, etc	c. 28f. Lo	cation (St		Rural Route Number, City
Divis pital or At ours after d ieral Direct	Certification:	4 Homicide determined (Specify)					UK O	TOWN, OLE		业
Division of Vital Records, P.O. Box 68 To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death. The Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier 1 Certifying Physician: To the best of my lone)  2 Medical Examiner: On the basis of examiner:								
To the within To the comple	Medical	2 Medical Examiner: On the basis of examinand manner stated  29b Signature and title of certifier	Traction and of the	oogaa	29c, License				29d. Date signed (/	
100	~	Poly A service and this of sorting	DODO	2	O.C.N				July 24, 2006	nonan, Bay, reary
J. K. W.		30. Name and address of person who completed cause of dea	ath (Item 23a)	L						···
Sh		Patricia Ardnica-Pollak MD. Assistant Me		ner	111 Penn Str	reet, Ba	Itimpre, MD	21201		Į.
S	tate	31. Date filed (Month, Day, Year) 32. Registrar's	Signature	-	-N 5					
Regis	trar	IIII 2 5 2006 Line		100	ASL.		<del></del>			
DHMH 17 Rev 1/2	2001	JOL	ORI	<b>GINAL</b>	_					

DHMH 17 Rev 1/2001 OCME 2006

06-05280 Paul Alan Lauchle

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Death Registrar	Reg No. 2006 2226
Physician/ Medical Examine	1. Decedent's Name (First, Middle, Last) A. Lauchle	2. Date of Death Month Day Year July 21, 2006  3. Time of Death 0623 hrs
-	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death Interstate 83 @ Belfast Road  Sparks	4c. County of Death Baltimore County
Funeral Director	5. Social Security Number 6. Sex 17. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs Months Days Hours Min.	
Maryland 28a-f show any 1 at once. ector	Usual Residence of Decedent  10a. State  10b. County  10c. City, Town or Location  10c. City, Town or Location  10c. City, Town or Location	10d Inside City Limits 1 Yes 2 No 10g Citizen of What Country?
the Maryland has or 28a-f sho	430 A Colonial rd. 17109	USA
imore, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland men to Fleath and Mental Hygiene fant: If item 27 is marked other than "natural", or items 23a or 28a-f sho or other traumatic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director	11. Marital Status 1 Never Married 2 Married Armed Forces? 1 Widowed 4 Divorced If yes 2 No 1 Yes, Sive Year or Dates 12. Was Decedent of Hispanic Origin? (Sp. If Yes, specify Cubap, Mexican, Puerto 1 Yes, Sive Year or Dates	
5-0036 ed within 72 hours aft ed within 72 hours aft other than "natural" the Medical Examine Completed by	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4 or 5+)  College (1-4 or 5+)  College (1-4 or 5+)	
D 21215-0036 should be filed within 7 and Mental Hygiene 7 is marked other than natic event, the Medical To Be Combit	Morton Lauchle Dor	(First, Middle, Maiden Surname)
and 2 should and 21 seem 27 is may traumatic every	Kathleen J. Lauchle 430 A Colonial ra	Rural Route Number, City or Town, State, Zip Code)  A. Harri Sburg, PA 17109  Date 20c. Location - City & Town, State
Baltimore, M permit. Pages I and 2 Department of Health Important: If item 2 injury or other traun	1 Burial 2 Cremation 3 Removal from State crematory or other places of cre	7/06 Hamsburg, PA
ញ់ ឱ្យី ឨ្មី ឨ្មី Physician /Medical	23a. Fart I. Enter the steel se, or a mplic it institut caused the drath. Do not enter the mode of dying, such as cardiac of failure. List only in cause on each line.	or respiratory arrest, shock, or heart Approximate Interval Between Onset and
Examiner	Immediate Cause (in all disease or condition resulting in death)  a. / cute Coronary Artery Thrombosis  Due to (or as a consequence of):	Death
led Insit	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated	
760, icate be executed physician and the burial - transit	events resulting in death) Last  Due to (or as a consequence of)  d.	
760, licate be executive by physician and the burial - transmitted the	UNPENDED AMENDED  IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
the death certificate be executed the death certificate be executed by the attending physician and ched for use as the burial - transi Physician/Madical E	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)  9 Unknown	,
head head	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 V Unknown
Division of Vital Records, P.O. ta alor Attending Physician: The law requires that it safter death.  **All Directors After this certificate has been signed by led in by the funeral director, page 2 should be detacted by the funeral director, page 2 should be detacted.		24a Was an autopsy performed?  1 ✓ Yes 2 No 24b. Were autopsy findings available prior to completion of cause of death?  1 ✓ Yes 2 No
tal Rician: Tician: Tician: Tician: Po C	25. Was case referred to medical examiner?  Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other Nursin	only one)  ng Home 5 Residence 6 ✓ Other: Scene
of Vi	1 ✓ Yes 2 No III Inparent 2 ENOutpatient 3 00A 4 Nursin  27. Manner of Death  28b. Time of Injury (Month, Day Year)  (Month, Day Year)  28c. Injury at Work?	28d. Describe how injury occurred
trendin death ctor: A y the fu	1 V Natural 5 Pending 2 Accident Investigation	
ig in a fine in contract of the contract of th	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc.  (Specify)  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	28f. Location (Street and Number or Rural Route Number, City or Town, State)
To the Ho within 24 To the Fu mpletely	Check only  One)  Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated	
	29b Signature and title of certifier 29c. License number O.C.M.E.	July 21, 2006
()	Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 212	201
Stat Registra		

DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. -2. Date of Death Decedent's Name (First, Middle, Last) Month Year **Physician** ETHEL MARION LONG 3:30 AM TULY 2006 /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner HEALTH RFORD BEL AIR BEL AIR If Under 1 Year Il Under 24 Hrs. 8. Date of Birth June 30, 1917 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Hours Min 89 218-03-3163 1 □ M 2 💢 F MaryTand Yrs. Director Usual Residence of Decedent 10b. County 10a, State 10c. City, Town or Location 10d. Inside City Limits or 28a-f ehow permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Deperment of Health and Mental Hyglene. Importent: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f ehov amy Injury or other traumatic event, the Madical Examinating Light and ODE. Bel Air MD Harford 1 ☐ Yes 🎗 ☐ No Completed by Funeral Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code USA 1007 A. Running Creek Way 1014 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married White 1 ☐ Yes 2 X No Specify: 3 ☐ Widowed 4 ☑ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working 15. Decedent's Education 16h. Kind of Business/Industry (Specify only highest grade completed) Retail **Epsteins** Elementary/Secondary (0-12) College (1-4or 5+) 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Wilmur Deshon Maria Buyer 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1007 A. Running Creek Way-Bel Air, Maryland 21014 Jeanette Karras-Daughter 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition Moreland Memorial 1 ☒ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Parkville, Maryland 7-25-06 Park 21. Signature of Funeral Service Licensee 22. Name and Address of Facility EVANS FUNERAL CHAPEL 3 Newport Drive-Forest Hill, Maryland Condral = fadd 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence ol) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner attending physicien and for use as the burial-transit Hospital or Attending Physicion: The law requires that the death certificate be executed Que to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No
9 Unknown Month 4☐Pregnant at time of death 5 Other (specify) this certificate has been signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? filled in by the funeral director, page 2 should be 1 Yes 2 4 Onknown Be Completed 24a. Was an autopsy perform 24b Were autopsy findings available prior to completion of eause of death?

1 Yes 2 No 1□ Yes 2□ No 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Certification: To 1 Tes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 28c. Injury at Work? 28a. Date ol Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Natural 5 Pending 1 Tes 2 No investigation 24 hours after death.

Funeral Director: A 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical completely 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated. To the within 2.

29c. License number

death (Item 23a) (Type, Print)

Registrar DHMH 17 Rev 1/2001

State

Baltimore, Maryland 21215-0036

of Vital Records,

Division

2006

29b. Signature and title of certifier

30. Name and address of person

			For State	State of Marylan	_	artment of rtificate o			2.0	06	23265
			Registrar  1. Decedent's Name (First, Middle, Last	)	00	Tincale O	Dealit	2. Date of Dea	Reg. No. U	0 0	3. Time of Death
	Physicia			Alfred	1		Lyle	Month	Day	Year 2000	145 PM
	/Medic Examin		James  4a. Facility Name (If not institution, give			4b. City, Town	or Location of Dea	th	4c. County		1. 10
	Examin	٠.	Maryland Genor	al Hospital		Bal	hmare (	itu			
	Funeral		5. Social Security Number 6. Se	7.1	ast birthday)	If Under 1 Year Months Day			h v. Year)	9. Birthp	place (State or Foreign
	Director		217-34-7703	67	Yrs.			03 2	y Year) 39		MD
	and **		Usual Residence of Decedent  10a, State 10b, County	10c. City	, Town or Lo	ocation				1	Od. Inside City Limits
	Manyli feho	ō	MD NA		ltime						1 XYes 2 ☐ No
	28e	Director	10e. Street and Number			10f. Zip Code	)		10g. Citizen of W	√hat Cour	ntry?
	3a or		2201 1/2 North	Fulton Ave		2	21217		U.	S.A.	
	be filed within 72 hours after death with the Maryland Hygiene. A Hygiene. d other then "neturel" or teme 23a or 28e-f ehow event, the Medical Examb ar must be codified at	Funerai	11. Marital Status	12. Was Decedent Ever in U. Armed Forces?	S. 13.	Was Decedent o	l Hispanic Origin? ( uban, Mexican, Pue	Specify Yes or No	- 14. Race	e - Americ k, White,	can Indian,
Q	or Ite	F	1 Never Married 2 Married	1 ☐ Yes 💥 ☐ No If Yes, Give		1 ☐ Yes 2 🛣 N		ito rinoari, oto.,	Specify		
ğ	ure!;	d by	3 Widowed 4 Divorced	Year or Dates:						Е	Black
ç	"net	Completed	15. Decedent's Edu (Specify only highest grad	le completed)	16a. Dece (Give	dent's Usual Occ kind of work dor DO NOT use reti	upation ne during most of wo red)	orking	16b. Kind of Bu	siness/In	dustry
2	filed within 72 Hygiene. Sther then "nei ent, the Medic	E C	Elementary/Secondary (0-12) 9th grade	College (1-4or 5+)  na		Contrac			Home I	mpro	ovement
D D	e filed wall Hygier I other the	Be C	17. Father's Name (First, Middle, Last)					me (First, Middle,			
au		To B	David R. Lyle				Kisiah	Talley	7		
Maryland 21215-0036			19a. Informant's Name/Relationship (T	/pe, Print)			et and Number or F				21213
	l and 2 Health a Im 27 Io		Grace Patterson				Coldspri		, Balt	imo	re, Md
ore O	0 0		20a. Method of Disposition  X□ Burial 2 □ Cremation 3 □ I	Removal from State	lace of Displemetery, cre	osition (Name of matory or other p		Date	20c. Location -	-	
altimore,	. Peges tment of tent: If It		4 □ Donation 5 □ Other (Specify,	Ark		Memori		8/06	Arbutu	s, N	Md
Bai	permit. Peg Department Importent: I eny Injury o		21. Signature of Funeral Service Licens	e alisoit	M	2. Name and Add	H West	D-146		ма	21215
	40200		13a. Pa 1. Enter the disease, or comp	lications that caused the death			oash Ave			Ma	Approximate
			s ock, or heart lailure. List only ommadiate Cause (Final	ne cause on each line.	50 1101 011	S Anaron	ying, soon as sarak	o or roopilatory a	11031,		Interval Between Onset and Death
	Pnysician /Medical		disease or condition regulting in death)	aDue to (or as a conseq	ry to	ville				-	
	Examiner		V	Auron Time	ninnd	eficier	na Virus				
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a conseq	uence of):	2.10.0	3				
	nd ransi	Examiner	that initiated events	с							
20,	cate be executed physicien end the burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):						
8760,	physic the b	dical	•	d						-	
9 X	eath certific ettending p for use as	Physician/Me	IF FEMALE:	23c. If yes, outcome of pregna	incy				23d Dat	te of delive	an.
Box	etter etter	clar	23b. Was decedent pregnant in the past 12 months?  1 □ Yes 2 □ No	1 Live birth 2 ☐ Feta 4 Pregnant at time of d	Ideath 3	⊒Ectopic pregnat ⊒ Other (specify)			Mor		Day Year
o.	t the c	hysi	9 Unknown	9□ Unknown							
ري ص	The law requires thet the death certific sie has been signed by the ettending p paga 2 should be detached for use as	by P	Part II. Other significant conditions of	ntributing to death but not res	ulting in the	underlying cause	given in Part I.	23e. Did t	obacco use conti	ribute to t	he cause of death?
ğ	w require been sign should b	Pe						10	Yes 2 □ No	3 Prot	bably 4 Dunknown
မင္ပ	e law r has be ja 2 sh	Completed						24a. Was	psy p	prior to co	opsy findings available impletion of cause of
<u>۔</u>	ysicien: The l is certificete ha director, paga	5							rmed?	death? I∐Yes	
/ita	icien: Th certificete rector. pag	Be	25. Was case referred to medical examiner?	Hoopitali		J.		eath (Check only o	one)		
of o	Physi this c al dir	7	1 195 2 910	Hospital:		nt 3L DOA		Home 5 Resi			fy)
u C	ding l h. After tuner	lo.	27. Manner of Death  1 Natural 5 Pending  2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		njuryat Vork? □ Yes 2 □ No	28d. Describe	how injury occurr	ea	
Division of Vital Records,	or Attending Physicien: after death. Director: After this certificd in by the funeral director.	licat	3 Suicide 6 Could not be		ome, larm, s			281, Location (	Street and Numb	er or Run	al Route Number.
<u>≤</u>	after after Dire	Certification:	4 Homicide determined	building, etc. (Specif	y)			City or To			
	To the Hospital or Attending Ph within E4 hours after death. To the Funeral Director: After th completely tilled in by the funeral		29a. Certifier 1 Certifying Ph	vsician: To the best of my kno	wledge, dea	th occurred at the	time, date and pla	ce, and due to the	cause(s) and ma	inner as s	stated.
	he Ht in 24 he Fu pletel	edical	(Check only 2 Medical Examone)	iner: On the basis of examina and manner stated.	tion and/or i			curred at the time,	date and place,	and due t	o the cause(s)
		Σ	29b. Signature and title of certifier	A A P		29c. Lice	ense number		29d. Date signed		
١,	Y		TASolve	IVID		- 2	37516		1-23	2-01	Q
2	200		30. Name and address of person who o	completed cause of death (Iter	п 23а) (Туре		ا ما ا	1 11	المالة		
	C4	ate	31. Date filed (Month, Day, Year)	2010 11 32 Registrar's Signa	11), C	10 IIIWY	land Gene	eral Has	pital		
3	Regist		1111 2 5 200	M.	M. 63	me					

#### Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. U G 2. Dete of Deeth 3. Time of Death 1. Decedent's Name (First, Middle, Last) Dev 6:30 PI 2006 Millette July Linsley 4b. City, Town, or Location of Death 4c. County of Death 4a Fecility Name (If not institution, give street end number) Baltimore Harbor Hospital If Under 24 Hrs. 8. Date of Birth Hours Min. (Month, Day, Year) Birthplace (Stete or Foreign Country) If Under 1 Year 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Months Devs 1 ☐ M 2 ☐ F Yrs. Connecticut 92 July 16, 1914 041-05-9865 Usuel Residence of Decedent 10d. Inside City Limits 10b. County 10c. City, Town or Location 1 ☐ Yes 2 ☐ No Maryland Baltimore Windsor Mill 10g. Citizen of What Country? 10f. Zip Code 10e. Street end Number 5713 01d Court 21244-1148 United States of America Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U,S. Armed Forces? 11 Marital Status 1 Yes 2 No If Yes, Give X Year or Dates: 1 □ Never Married 2 □ Married Specify: White 1 ☐ Yes 2 X No Specify: 3 Widowed 4 □ Divorced 16e. Decedent's Usuel Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Contracting College (1-4or 5+) Plumbing Heating Contractor Elementary/Secondary (0-12) Construction 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Neme (First, Middle, Last) Gladys Morgan Unknown 19a. Informant's Name/Reletionship (Type, Print) 19b. Mailing Address (Street and Number or Rurel Route Number, City or Town, State, Zip Code) (Daughter) 700 Lombardy Ave., Newport News, Virginia 23606 Deborah L. Linsley 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 □ Burial 2 □ Cremation 3 □ Removal from State Lake View Memorial Park 07/26/06 Sykesville, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Loring Byers Funeral Directors, Inc. 21. Signature of Funeral Service Licensee COlnor Moo333 8728 Liberty Road, Randallstown, Maryland 21133 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Bilateral freumonia Acute renal tailure Due to (or es e consequence of): Esophageal Cano 23b. Did tobacco use contribute to the cause of death? 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings aveilable prior to completion of cause of deeth? 24a. Was an autopsy performed?

Physician /Medical Examiner

**Physician** 

/Medical

Examiner

Director

Funeral

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Completed

Be

Funeral

Director

filed within 72 hours after death with the Maryland Hygiene. hther than "natural", or tems 23s or 28s-1 show

3altimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760

requires that the death certificate be

I or Attanding Physician: eftar death.

eral Director: After th filled in by tha funeral

To the Hospital o within 24 hours of To the Funeral Di completaly filled in

7 is marked other than "natural", or items 23e or 28e-f shor traumatic event, the Medical Examinal must be notified at

pernit. Peges 1 and 2 should be filed i Depertment of Health end Mental Hygie Important: If Item 27 is marked other i any injury or other traumatic evant, II

Examiner Physician/Medical ρ Completed Be Certification: To

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Ceuse (Disease or injury that initieted events resulting in death) Last

29a. Certifier

Medicai

Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 26. Place of Death (Check only one)

25. Was case referred to medical examiner?
1 ☐ Yes 2 ☐ No Hospitel: 1 Inpatient 27. Manner of Death 1 ☑ Naturel 5 ☐ Pending investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide

2 ☐ ER/Outpetient 3 ☐ DOA

28c. Injury at Work? 1 ☐ Yes 2 ☐ No 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, Stete)

28d. Describe how injury occurred

Other: 4 Nursing Home 5 Residence 6 Other (Specify)

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) end manner as steted.

2 Medical Examiner: On the basis of examination end/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) end manner stated. (Check only one) erin Price MD

29c. License number RESDOD 29d. Date signed (Month, Day, Yeer)

1 ☐ Yes 2 No

30. Name end eddress of person who completed cause of death (Item 23e) (Type, Print) Hanover Street Baltimore Md 21225 5, 3001 Price

31. Date filed (Month, Dey, Yeer)

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 23267 1 - State Registra Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Year **Physician** Lamartina 1340 M Logan JULY 20 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOPKINS HOSPITAL

6. Sex 7. Age (In yrs. last birthday) N/A Baltimore Johns 5. Social Security Number If Under 1 Year If Under 24 Hrs Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 11☑M 2□F Director 4 June 16,2006 Maryland 218-75-3214 N/AUsual Residence of Decedent 10b. County 10c. City. Town or Location 10d. Inside City Limits 10a. State worle or 28a-f show Dundalk 1 ☐ Yes 2 No Directo Maryland Baltimore the 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r then "natural", or Iteme 23s or the Medical Examiner must be a 825 Jaydee Ave. United States 21222 death by Funeral 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. Pages 1 and 2 should be filed within 72 hours after nent of Health and Mental Hygiene. 1 Never Married 2 Married 1 ☐Yes 2 ☑ No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced Year or Dates: White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) College (1-4or 5+) Elementary/Secondary (0-12) N/A Dependent N/A 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Angela S. Miller 2 Samuel E. Lamartina 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Health a Dundalk, Maryland 21222 825 Jaydee Ave. Angela S. Baker (Mother) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1
Department of H
Important: If Ite
any Injury or ott 1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify) Entombrent Holly Hill Mem. Gdns. 7/24/2006 Middle River, MD 21. Signature of Ameral Service Licenses 22. Name and Address of Facility Duda-Ruck Funeral Home of Dundalk, Inc. Regor 7922 Wise Ave. Dundalk, Maryland 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or hear failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** PNEUMOTHORAX HOURS /Medical Due to (or as a consequence of): Examiner HypopLASTIC DAYS ONGENITAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) sician and burial-transit Examir To the Hospital or Attending Physician: The law requires that the death certificate be executed OMPHALOCELE DAYS Due to (or as a consequence of) O. Box 68760. Physician/Medical he attending p IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) ed by the detached 9 Unknown 9 Unknown ۵. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records. \$ 1 Yes 2 XNo 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy certificate 2 No 1 Yes Division of Vital 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) ٩ 1 ☐ Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA this 28b. Time of Injury 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: After 5 Pending investigation 1 Natural death. 1 Yes 2 No 2 Accident Director: 6 ☐ Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours at To the Funerel C completely filled i filled 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier RES-000 MID JULY 20 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 N. WOLFE J.B. CANTEY SI BALTIMORE MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 5 2006 Registrar

		ic	For State Registrar	State of Mary		artment rtificate			and M	ental Hy	ygiene Reg. No.	200	6	23268
e . Pi	nysicia		1. Decedent's Name (First, Middle, La	,						2. Date of D Month	Day	~ X	ar •	3. Time of Death
1	Medic	al -	Marjorie Cre		night	4b. City, To	own or l	Location o	of Death	2014	23	County of		6.101M
	xamin	er	Washington County	,				stown			40.			ton Co.
Fui	neral		5. Social Security Number 6. 5	Sex 7. Age (In	yrs. last birthday)	If Under 1		If Under		8. Date of B (Month, D March	irth (av. Year)	9	Birthpl	ace (State or Foreign
<u>a</u> △ Dire	ector	-	203 10 3337	1 □ M 2 <b>X</b> □ F	86 Yrs.	Months				March	19,19	20	Penr	nsylvania
land	10		Usual Residence of Decedent  10a. State 10b. County	100	c. City, Town or Lo	cation							10	Od. fnside City Limits
e Man	Illiad	ctor	Maryland Washin	gton Co.	Hagerst	own								1 □ Yes 2 No
11215-0036 within 72 hours after death with the Maryland ene.	ound that institute, or restaurable to contention avent, the Madical Examinet must be notified at	Funeral Director	10e. Street and Number	nia Avanua		10f. Zip C		21742				en of Wha		•
leath v	TAME	erai	1304 Pennsylva	12. Was Decedent Ever	in U.S. 13.	Was Decede				cifv Yes or N		4. Race -		
6 after o	alner	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No		ff Yes, specif 1 ☐ Yes 2		Specify:	, Puèrto	ncify Yes or N Rican, etc.)		Black,	White, 6	etc.
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10 0 m	2 3 1		19a. Informant's Name/Relationship	**		ng Address (				Hagers	-		te, <i>Zip</i>	
Hear Hear	other tr	ì	20a. Method of Disposition	20	Ob. Place of Dispo cemetery, crei					ate		ation - Cit		
	ury or		1	Removal from State	Spring Hi	ill Cer	nete	ry 📋	7/27	/2006	Shi	ppens	bur	g, PA
Baltimore, permit. Pages 1 a Department of Heis	any injury or once.		21. Signature of Funeral Service Lieg	nsoo	22	2. Name and Leona				Inc.	5305 Balt	5 Har timor	fore	d Rd. MD 21214
ige j	.d. 1		23a. Part1. Enter the disease, or con shock, or heart failure. List only	plications that caused the one cause on each line.							arrest,			Approximate Interval Between Onset and Death
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P.O. F	96	Physician/Med	1 □ Yes 2 □ No 9 □ Unknown	4□Pregnant at time 9□ Unknown	of death 5	Other (spec	cify)					Wieria		Day Tour
s that	gried by be detac	by Ph	Part II. Other significant conditions	contributing to death by no	t resulting in the u	inderlying cau	ise give	n in Part I.		23e. Did	tobacco us	e contribu	ite to th	e cause of death?
ords equire	should b	ted b	Varier	word de	reas-	/				1 🗆	Yes 2	No 3[	] Prob	abfy 4 □Unknown
Records,	20	Completed	meta	whi en	cephal	opayn	7			24a. Wa aut	opsy	prio	r to con	osy findings available inpletion of cause of
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of Vital Physician: T	directo	To Be	25. Was case referred to medical examiner?	Hospital:	2 ER/Outpatier	nt 3 DOA	Othe	-		n <i>(Check only</i> me 5 ☐ Res		Other	Space	,ì
	funeral di		27. Manner of Death	28a. Date of Injury (Month, Day Yea	28b. Time o		c. Injury Work			28d. Describe			Opecny	/
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= 5 # F	d in by the	Certification:	4 Homicide determined		At home, farm, sti pecify)	reet, factory,	office		1		(Street and own, State)	l Number (	or Rura.	Route Number,
To the Hospital or within 24 hours after	completely filled in by the funeral	Medical C	29a. Certifier 15 Certifying P	hysician: To the best of my miner: On the basis of exa and manner stated.	y knowledge, deat mination and/or in	h occurred at westigation, i	the time	e, date an inion, dea	d place, a	and due to the	e cause(s) : e, date and	and mann place, and	er as st due to	ated. the cause(s)
To th within	сошр	W	29b. Signature and title of certifier	Λ -		29c.	License	number			29d. Date	signed (	Aonth, L	Day, Year)
			1 ky	117	M.D.		100	041	131		Ju	Ly 2	31	2006
1			30. Name and address of person who	completed cause of death	(Item 23a) (Type,	Print) (12	24	OF	sel a	COUV	1 21	74	2	
The same of the sa	Sta	te	31. Date filed (Month, Day, Year)	32. Figistrar's S	Signature	1 -1	6.00	100	1000	0001	) 00	( (		
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State of Maryland / Department of Health and Mental Hygiene 1 = For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1 Decedent's Name (First, Middle, Last) Day 2006 July 21, **Physician** 10:30 AM Halina Leichthammer /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month, Day, Year) Montgomery Rockville 5901 Spaatz Place If Under 1 Year | If Under 24 Hrs. Birthplace (State or Foreign
Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Days Hours Min 1 □ M 2 X F Poland 93 Director 214-04-1437 Usual Residence of Decedent the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Importent: if item 27 is marked other than "natural", or items 23e or 28e-1 show any injury or other traumatic event, in Medical Exeminar must be notified at once. or 28a-f show 1X Yes 2 No Rockville Directo Maryland Montgomery 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number Poland 5901 Spaatz Place 20851 Completed by Funeral Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☐ Yes 2X No If Yes, Give 1 Never Married 2 Married White Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: Specify: 3 Widowed 4 □ Divorced Year or Dates 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) Coitege (1-4or 5+) Own Home Homemaker 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Zofia Domzalowicz Wladyslaw Marcin Wyrzykowski 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Elizabeth Siwanowicz/Dtr-in-Law 5901 Spaatz Place, Rockville, Maryland 20b. Place of Disposition (Name of cemetery, crematory or other place) July 23, 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 X Cremation 3 ☐ Removal from State Montgomery Crematorium 2006 Bethesda, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee Robert A. Pumphrey Funeral Home, Rockville, Inc. 20850 Mullicum a. M01173 300 W. Montgomery Avenue, Rockville, Maryland mes 23a. Part1. Enter the disease, or comblications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Immediate **Physician** Cardiac Arrest /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dualto (or as a consequence of) Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed the burial-transit Due to (or as a consequence of): Box 68760. physician for use as IE FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🕅 No 5 Other (specify) 4 Pregnant at time of death P.O. 1 be detached 9 Unknown þ Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. þ 1 Yes 2 No 3 Probably 4 Unknown Hypertension page 2 should Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 20 No 1 ☐ Yes 2 ☐ No certificate 1 Yes After this certific funeral director, 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5X Residence 6 Other (Specify) 1 ☐ Yes 2 🛣 No Certification: To 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 27. Manner of Death 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No death. investigation 2 Accident hours after deat 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) þ within 24 hours after To the Funeral Direcompletely filled in b 4 T Homicide 29a. Certifier 1 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number July 23, 2006 D0051779 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6000 Executive Blvd., #300, Rockville, Maryland 20852 Cullen, M.D. William J. 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 2 5 2006 10 aure Registrar

			For State Registrar	State of Maryland				ealth and N D <i>eath</i>		ene2 ()	06	23270	
	Physicia		1. Decedent's Name (First, Middle, Last) C •	Jeanne M	atthew	s			2. Date of Death Juny 22		Year	3. Time of Death 7:30 A M	
	/Medic Examin		4a. Fecility Name (If not institution, give s Mariner Health An				Town, or	Location of Death		4c. County		lel County	
	Funeral Director		5. Social Security Number 6. Sex 213-30-5642	7. Age (In yrs. I 75	ast birthday) Yrs.	If Unde Months	r 1 Year Days	If Under 24 Hrs. Hours Min.	8. Date of Birth Feb. 05,	1 <b>9</b> 31	9. Birthi Coul F1c	place (State or Foreign ntry) rida	
	faryland	o.	Usuel Residence of Decedent  10a. State 10b. County Maryland Anne Aru	ndel 10c. Cin	, Town or Lor asaden	cation 1a						10d. Inside City Limits 1 ☐ Yes 2 ☒ No	
	or 28a-1	Direct	10e. Street and Number			10f. Zi	p Code	າາ	10	g. Citizen of U.S		ntry?	
0	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If term 27 is marked other then "naturel" or teme 23a or 28a-f show any Injury or other traumatic event, It a Medical Examinar must be notified at once.	by Funeral Director	1 Never Married 2 Married	2. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 No If Yes, Give	11	Was Dece f Yes, spe	dent of Hi	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No- p Rican, etc.)	14. Rad	ce - Amenick, White,		
200-612	nin 72 hours in "naturel" Medical Ex	Completed b	3 ■ Widowed 4 □ Divorced  15. Decedent's Educ (Specify only highest grade  Elementary/Secondary (0-12)	Year or Dates: ation completed) College (1-4or 5+)	16a. Deced (Give life. L	dent's Usu kind of w DO NOT u	ial Occupa ork done d use retired	ation during most of work )	king	6b. Kind of B	usiness/In	dustry	
7 7 7	illed with Hygiene ther the nt, the	Com	12	0	I.	lachi	ne O	perator 18. Mother's Nam	ne (First, Middle, N	Mail B Maiden Sumar		nc.	
Jiana	should be find Mental B marked of	To Be	John	Vandervort				Vera	Ross				
Mar	lith and 27 is mu		19a. Informant's Name/Relationship (Type Regina L. Mullen	e, Print) (Daughter)					<i>ral Route Number.</i> Len Burni				
Jore,	Pages 1 arent of Hearnint: If Item		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ Ref	imovai irom state	lace of Dispo emetery, cren			1		20c. Location			
Бант	permit. Pa Departmer Important any Injury		Glen Haven Mem. Park 07-25-06 Glen Burnie,  21. Signature of Funeral Service Licensee  22. Name and Address of Facility McCully-Polyniak Funeral Home P.A.  3204 Mountain Road, Pasadena, Maryland										
		23a, Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,											
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	Aspiration Due to for as a consequence		umo	nia					Onset and Death	
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C. Box	the death certificate be executed the ettending physicien and the other use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ Mo 9 □ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	death 3	Ectopic p Other (s	pregnancy specify)				ate of deliv	ery Day Year	
rds, r.	The law requires that the death site hes been signed by the etter age 2 should be detached for	ğ	Part II. Other significant conditions con	tributing to death but not res	ulting in the u	nderlying	cause giv	en in Part I.	23e. Did tob		tribute to t	the cause of death?	
I Records,	The lav ete hes page 2	Completed	Dementia						24a. Was ar autops perform 1 Yes 2	24b.	death?	opsy findings available ompletion of cause of	
VItal	rsician: Th s certificate lirector, pag	o Be	25. Was case referred to medical examiner?  1  Yes 2 No	ospital: 1 □ Inpatient 2 □	ER/Outpatier	nt 3 🗆 🗅	Oth Oth	00	th <i>Check</i> o <i>nly one</i>		her /Speci	fv)	
Division of	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific completely illed in by the funeral director.	<del> </del>	27. Manner of Death  1  Atural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury		28c. Injun Wor		28d. Describe ho			97	
DIVIS	To the Hospital or Attending I within 24 hours effer death.  To the Funeral Director: After completely filled in by the funer	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At he building, etc. (Specif		reet, facto	ry, office		28f. Location (Str City or Town		ber or Run	al Route Number,	
	Hospita 24 hours Funera stely fille	Medical C	29a. Certifier 1 Certifying Physical (Check only one)	ician: To the best of my known of the basis of examina and manner stated.	wledge, death tion and/or in	h occurre vestigatio	d at the tin in, in my o	ne, date and place pinion, death occu	, and due to the ca rred at the time, da	use(s) and mate and place,	anner as s and due t	stated. to the cause(s)	
	To the within To the comple	Me	29b. Signature and title of certifie	. On no			9c. Licens		29	9d. Date signe	ed (Month,	Day, Year)	
}	, X		30. Name and address of person who co	mpleted cause of death (Iten	n 23a) (Type.	Print)		61312		01/0	14/0	0.	
	10			SHALL 7445	EF	URN	ACE	BRANCH	RD GL	EN BU	PNIE	MD 21060	
	Sta Registi		1111 2 5 2005	. negistral s olgit	600	A STATE OF THE PARTY OF THE PAR							

			For State Registrar	State of Marylan		artmen rtificat			nd Me		giene Reg. No.	2006	23271
			1. Decedent's Name (First, Middle, Last)							Date of De		Year	3. Time of Death
	Physicia /Medic		Annie Rut	h Moore						July	21	200 É <sup>ear</sup>	4:26a м
)	Examin		4a. Facility Name (If not institution, give s			4b. City,	Town, or L	ocation of	Death		4c.	County of Death	1
			Riverview Nursi	ng Center		1	Esse					Baltim	ore
	Funeral		5. Social Security Number 6. Sex 218-12-2724 1□	NF -		If Under Months		If Under 2 Hours	Min. 8	Date of Bir (Month, Da OCt. 1	th y Year)	9. Birth	place (State or Foreign intry)
	Director		Usual Residence of Decedent	M 264F 8!	5 113.					UCE.	4,1	920	30
	and and	ŀ	10a. State 10b. County	10c. Cit	ty, Town or Lo	ocation							10d. Inside City Limits
	Mary f ehc	ō	MD Baltime	ore	Rosed	lale							1 ☐ Yes 2 ☐ No
	28s	Funeral Director	10e. Street and Number			10f. Zip	Code				10g. Citi	zen of What Co	untry?
	3a o		1811 Weyburn	Road		2	1237	,			T	JSA	
	ms 2	Jere		12. Was Decedent Ever in U	I.S. 13.				in? (Specif	fy Yes or No		14. Race - Amer Black, White	
9	or Ite		1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 <b>X</b> No If Yes, Give		1 ☐ Yes		Specify:	7 00110 111	Dan, Gio.)		Specify: Wh	•
<u>ള</u>	ours	g P	3 Moderated 4 □ Divorced	Year or Dates:									
Maryland 21215-0036	72 h 'natu	Completed by	15. Decedent's Educ (Specify only highest grade	ation completed)	(Give	dent's Usua kind of wo	rk done du	tion uring most	of working	,		nd of Business/I M Clea	•
2	vithin Pan	ם	Elementary/Secondary (0-12)	College (1-4or 5+)	Own	DO NOT I	se retirea)				اهج	M Clea	ners
7	ilied within 72 hours after death with the Maryland Hygiene. Hysiene. Hite Madical Examirer must be notified at ent, the Madical Examirer must be notified at	ပ္ပ	12th 17. Father's Name (First, Middle, Last)		1 0 11-12			18. Mother	's Name (	First, Middle	. Maiden	Sumame)	
_	m = 0 5	Be	Edward Surles							urne			
2	2 should be filed within 72 hours after death with the Marylan and Memtal Hygiene and Memtal Hygiene is marked other than "naturel", or items 23a or 28a-f show sumatic event, the Modical Examiner must be notified at	ဥ	19a. Informant's Name/Relationship (Typ	oe, Print)	19b. Maili	ng Address						r Town, State, Z	ip Code)
<u>s</u>	trau		Howard G. Plumb							Rose			21237
ē,	tem tem other		20a. Method of Disposition	20b. I	Place of Dispo	osition (Nar	ne of		Dat		20c. Lo	cation - City or	
ڪ ا	age: entol nt: #		1 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from State Ga	rdens	of	Fait	h ¦	7/24	/06	Ro	ssvill	e MD
Baltimore,	permit. Pages 1 and 2 should by Depenment of Health and Menta important: if item 27 is marked any Injury or other trsumatic events.	1	21. Signature of Funeral Service License	19	/ 2	2. Name ar	nd Address	of Facility	30	0 Mac	e A	ve. Ba	lto. MD
m	Depermine timpo		K. Terry	onnell	11	Conr	nelly	y Fui					x 21221
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caused the deadle cause on each line.	/	ter the mod	te of dying,	, such as o	ardiac or r	respiratory a	rrest,		Approximate Interval Between
Ų,	Physician		Immediate Cause (Final disease or condition	Ad	hone	وو		D	emo	mha	٨		Onset and Death
	/Medical		resulting in death)	Due to (or as a consec	quence of):				-				
	Examiner		Sequentially list conditions	ı									
	ם ב	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a consec	quence of):								
	icate be executed physicien and s the burial-transit	am	Cause (Disease or injury that initiated events cresulting in death) Last	Due to (or as a consec	nuence of):								
760,	be ex icien burial	cai E		Due 10 (01 as a 0011360	4401100 01).								
	phys the			l									
×	ding ding se es	/Me	IF FEMALE:	3c. If yes, outcome of pregn	ancy							23d. Date of deli	verv
മ	that the death certifica ed by the attending ph detached for use es th	clar	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of c		⊒Ectopic p ⊒ Other <i>(s</i> p						Month	Day Year
o.	the d yy the achec	hys	9 Unknown	9□ Unknown									
<u>ر</u>	Physicien: The law requires that the death certifica this certificate less been signed by the attending phyral director, page 2 should be detached for use es the	by Physician/Med	Part II. Other significant conditions con	1 1 1	1 .	underlying o	ause giver	n in Part I.		23e. Did 1	obacco u	se contribute to	the cause of death?
Ĕ	w require been sig should b	ed	Chranc	Malnutri	nan	9	HJ	74		10	Yes 2	□No 3□Pr	bably 4 Onknown
000	law re	piet	Anemia	•		-				24a. Was		24b. Were au	topsy findings available ompletion of cause of
Ĕ	The lav	Completed									rmed?	death?	212 No
ij	ien: ortifice ctor. p	Bec	25. Was case referred to medical examiner?					26. Place	of Death (	Check only			
<u></u>	hysic his ce I dire	2	1 Yes 2 No		] ER/Outpatie			4 19 19 11				5 □Other (Spec	eify)
2	fter t	ë	27. Manner of Death  1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		28c. Injury Work			d. Describe	how injur	y occurred	
sio	leath.	cati	2 Accident investigation 3 Suicide 6 Could not be		,	М		es 2□N		M. Landina	04	/ N/ 1 0	
Division of Vital Records, P.O. Box	or At	Certification;	4 Homicide determined	28e. Place of Injury - At h building, etc. (Speci	ily)	reet, factor	у, описе		28	City or To			ral Route Number,
_	To the Hospitel or Attending Physicien: The I within 24 hours effet death.  Yo the Funerel Director: After this certificete is completely filled in by the funeral director, page		29a. Certifier 112 Certifying Phys	sician: To the best of my kn	dwiadaa daa	th oncurred	at the type	e date and	d place: an	d due to the	causa(s)	and manner as	stated
	24 h	edicai		ner: On the basis of examination and manner stated.									
	within To th comp	Me	29b. Signature and title of certifier			29	c. License	number		,	29d. Dat	e signed (Monti	n, Day, Year)
	1		AL M.D				D-	38	15	1	07	-21-	2006
4	,	8	30. Name and address of person who co	impleted cause of death (Ite	m 23a) (Type	Print)	DD.	1 1	LUT	) /	1.0	-21	2006 221
			31. Date filed (Month, Day, Year)	22. Registrar's Sign	Y · Z	175/		- FE		, ,	ヘン		
	Sta Regist		31. Date filed (Month, Day, Fear)	nna Process	JA A	good	P						

			State of Maryla	-			nental Hygi	ene	
			Registrar  1. Decedent's Name (First, Middle, Last)	Ce	rtificate of L	Jeath	2 Date of Death	g. No. 2006	2 3 2 7 2
	Physicia	an	Betty L. Moore				July 2	Day Year	-2' COPM
	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or	Location of Death		4c. County of Death	2.07
	Examili	EI	Heritage Nursing Center			ndalk		Baltimo	ore
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs	. last birthday)		If Under 24 Hrs. Hours Min.	8. Date of Birth	9. Birth	place (State or Foreign
	Director			72 Yrs.	WOTHITS Days	riours with.	July29	, 1933 Ma	ryland
	pue *	-	Usual Residence of Decedent  10a. State 10b. County 10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	f eho	5	MD Baltimore	•	lle Rive	r			1 Tyes 2 No
	the 128a	rec	10e. Street and Number		10f. Zip Code		10	g. Citizen of What Cou	intry?
	death with the Marylend rme 23a or 28a-f ehow ir must be nutitied at	<u>=</u>	2112 Souththorne Road		21	220		USA	
	deat	Funeral Director	11. Marital Status 12. Was Decedent Ever in the Armed Forces?	J.S. 13.	Was Decedent of Hi If Yes, specify Cuba	spanic Origin? (Sp	ecrfy Yes or No-	14. Race - Amer Black, White	
9	or it	F	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 💆 No		1 ☐ Yes 2% No	Specify:		Specify: Whi	
8	72 hours after netural', or ite dical Examina	d by	3 XWidowed 4 □ Divorced Year or Dates:	100 Dass	dentie Heist Ossiss	-61-m			
<del>,</del>	in 72	jet	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occupa kind of work done of DO NOT use retired	during most of work	ang	6b. Kind of Business/li	ndustry
212	filed within 7 Hygiene. other than *ent. the Mad	Completed	Elementary/Secondary (0-12) College (1-4or 5+)  11th	Hom	nemaker			own home	9
פ	othe vent.	Bec	17. Father's Name (First, Middle, Last)			18. Mother's Nam	e (First, Middle, M	laiden Sumame)	
<u>Ja</u>	should be nd Mentel marked o	70 [	Theodore Meyers			Nell	ie Lock	hart	
Maryland 21215-0036	C1 42 20 01		19a. Informant's Name/Relationship (Type, Print)					City or Town, State, Zi	
di.	1 end Heelth em 27 other tr		Joann Taylor /daughter  20a. Method of Disposition 20b.	-	Gravelo		-	ore MD 21	
Baltimore,	permit. Pages 1 Department of H Important: If Ite ony injury or ot		1 ☐ Burial 2 🖾 Cremation 3 ☐ Removal from State 📙 Ba	<i>септецегу сте</i> iyview	maton or other place.		-	Balto, MD	
뜶	nit. Pa bartmen cortant: injury is.		4 Donation 5 Other (Specify) 21. Signature of Funeral Service Unissee	2	2. Name and Addres	s of Facility 1	5/06	1 110 201	Tach.
Ba	Depa impo eny ir		Mallotten tolk		300 Mace	1	7	al Hone of 6 ore MD 21	1
			23a. Part1. Enter the disease, or complications that caused the dea shock, or heart failure. List only one cause on each line.						Approximate Interval Between
	Physician		firmediate Cause (Final disease or condition ATRIA)	16	2011	1 1 710	-> X/		Onset and Death
Т	/Medical		resulting in death)  Due to (or as a conse	quence of):	BAIL			26	
	Examiner		Sequentially list conditions.	TIVE	HEA	RTF	-ASLU	125	
	ed sit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury	quence of):		-n.c. D	)	Carl Dil	
	xecut and	хап	that initiated events resulting in death) Last C. Due to (or as a conse	quence of):	XXX	11/61	ULINO	1XAF	
8760,	death certificate be executed e attending physicien and id for use as the burial-transit	ical E	MALNIA	TRIT	ISN		67	とめつと	
9	g phy as the								
Вох	leath certifica attending ph	N/N	IF FEMALE: 23b. Was decedent pregnant 1 Live birth 2 ☐ Fet		⊒Ectopic pregnancy			23d. Date of deliv	
		Physician/Med	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of		Other (specify)			Month	Day Year
0.0	d by the a	Phy	a □ ∩ukuowu	oulting in the		on in Doct I	23a Did tob	acco use contribute to	the equal of death?
	iaw requires that the es been signed by th 2 should be detache	l by	Part II. Dther significant conditions contributing to death but not re	suiting in the t	indenying cause give	en in Pan I.		s 2 No 3 Pro	
Records,	w require been sign should b	Completed			<u>·</u>				
Rec	The lay	du					24a. Was an autopsy perform	ed? death?	opsy findings available empletion of cause of
Vital		Ö	25. Was case referred to medical			26 Place of Deat	1 ☐ Yes 2 th (Check only one	1 ☐ Yes	21 10
<u> </u>	Physicien: this certific ral director,	To B	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2	☐ ER/Outpatie	nt 3 DOA Othe	ac		nce 6 Other (Spec	ify)
n of			27. Manner of Death 28a. Date of Injury (Month, Day Year)	28b. Time of	of 28c. Injury Work	at	28d. Describe ho	w injury occurred	
Sio	Attending r death. ector: After y the fune	catic	2 Accident investigation			Yes 2 □ No			
Division	or Ati	Certification;	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined 28e. Place of Injury - At building, etc. (Spec	nome, farm, st :ify)	reet, factory, office		28f. Location (Str. City or Town,	eet and Number or Rui State)	al Route Number,
	Hospital or Atten 24 hours after deat Funeral Director: itely filled in by the	20	29a. Certifying Physician: To the best of my kn	nowledge deal	th occurred at the time	ne date and place	and due to the ca	usa(s) and manner as	etated
		dicai	(Check only 2 Medical Examiner: On the basis of examination and manner stated.	ation and/or in	vestigation, in my of	pinion, death occur	red at the time, da	te and place, and due	to the cause(s)
E.,	To the within 2 To the complet	Me	29b. Signature and title of certifier		29c. License	number	29	d. Date signed (Month	, Day, Year)
			Janney ( ) wall	MD	02	2188	2	7/2510	6
	Fo.		30 Name and address of person who completed cause of death (Ite	m 23a) (Type,	Print)	1-01		1 1	111
	1		31. Date filed (Month, Day, Year) 32. Registrar's Sign	2/	MOTICE	1 ples	e Ols	Mexic	102/222
	Sta Registr			nature	all I	t		,	
10		3	JUL 25 2006 Beaux A		-				

State of Maryland / Department of Health and Mental Hygiene

			Certifica	te of Death	Reg.	.No.2006	23273
	Physicia	an	Decedent's Name (First, Middle, Last)	- 4	2. Dete of Deeth Month	Day Year	3. Time of Death
wa.	/Medic	al	4a Facility Name (If not institution, give street end number)	nning 4b. City, Town, or Loc	100	25, 2006 4c/County of, Death	8:40Am
~/	Examin	er	Composition of the street of a line of the street of the s	Ra/L	100	Rollin	nare
-	Funeral		S. Coolar Coolary Harrison	er 1 Year If Under 24 Hrs.	8. Date of Birth (Month, Day, Ye	9. Birth	place (State or Foreign
В	Director		215-18-7815 1 Month 85 Yrs. Month	s Deys Hours Min.	6/26/19	21 Mar	yland
	pu .		Usuel Residence of Decedent  10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits
	laryle show	5	MD Baltimore Towson				1 ☐ Yes 2X No
	284-1	ect ect		ip Code	10g.	. Citizen of What Cou	intry?
	filed within 72 hours efter death with the Marylend Hygiene. ther than "natural", or flams 23a or 28e-f show ant, the Medical Examiner must be northed at	Funeral Director	1111 Hart Rd.	21286		USA	,
	death	ner	11. Maritel Status 12. Wes Decedent Ever in U,S. 13. Was Dec Armed Forces? 13. Was Dec	edent of Hispanic Origin? (Specify Cuban, Mexican, Puerto F	city Yes or No-	14. Race - Amer Black, White	
0	or its		1 Never Married 2 Married by Yes 2 No 1940 + 1 Yes	20XNo Specify:	110211, 010.)	Specify	
8	ural'.	d by	3 Wildowed 4 Divorced Year or Dates: 1 3 4 0		101	W	hite
21215-0020	in 72	Completed	15. Decedent's Education (Specify only highest grade completed) (Give kind of wind of	ual Occupation vork done during most of workin use retired)	g	b. Kind of Business/li	ndustry
212	be filed within tal Hygiene. Id other than event, the M	E	Elementary/Secondary (0-12) College (1-4or 5+) 12 Chief Fi	nancial Off:	icer S	tate of	Maryland
b	other vent,	Bec	17. Father's Name (First, Middle, Last)	18. Mother's Name			
<u>Jai</u>	ould b	To	Bernard J. Manning Sr.	Anna	a A. Bra	aunbart	
Mar	end end end			ss (Street and Number or Rura	Route Number, C	ity or Town, State, Zi	p Code)
e)	C # 12 F		Thomas M. Manning Sr. 3604 (20a. Method of Disposition (N	Glenarm Ave.	Onto 1 20s	c. Location - City or T	oum State
Baltimore, Maryland	ges or = 1			other place) .T1	ıly	Towso	
ij	Departmen Departmen Important: any injury		MXBurial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)  21. Signalure of upper Service Licensee  22. Name	Gardens 28	5, 2006 880	00 Harfo	
Ba	Deperment of the concession of	- 4	11/1/2011		Par		MD 21234
	_	-	23a/ Part1. Enter the disease, or complications that caused the death. Do not enter the mashock, or heart failure. List only one cause on each line.	Funeral Cha			Approximate
in	Physician		shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death
-4	/Medical		Immediate Cause (Final disease or condition	witimi a		1	
	Examiner -		resulting in death)  Due to (or as a consequence or	n)			
	be sit	Examiner	b				
	væcut e end al-tran	xan	Sequentially list conditions, if eny, leading to immediate cause. Enter Underlying Cause (Disease or injury	():		1	
68760,	The law requires that the death certificate be executed ate hes been signed by the attending physician end page 2 should be detached for use as the bunal-transit		I that initiated events	).		-	
	ng phy s as th	Medical	resulting in death) Last	<i>p</i> -			
Box	eath cer attendin I for use	any	d			1	
	e dea the at ned fo	Physiclan/	Part II. Other significant conditions contributing to death but not resulting in the underlying	cause given in Part I.	23b. Did toba	cco use contribute	to the cause of death?
P.0	res that the de signed by the a be detached i		Dementia		1 🗆 Yes	2☑No 3□Pro	obably 4 ☐ Unknown
ds,	signe d be d	d by			24a. Was an a	utonsy 24b. V	/ere autopsy findings
Ö	v require been sij should t	ete			performed	d? a	vailable prior to ompletion of cause
of Vital Records,	The law ate hes page 2	Completed			1 Vos	_/	ideath? □Yes 2□No
ta		Bec	25. Was case referred to medical	26. Place of Death		2400	
Ξ	ysicis s cert direct	To B	examiner?  1 Yes 2 V No Hospital: 1 Inpatient 2 ER/Outpetient 3 I	Other:		e 6 ☐Other (Spec	fy)
0	Attending Physician: or death. ector: After this certific by the funerel director.		27. Menner of Death 1 Unaturel 5 □ Pending   28a. Date of Injury (Month, Dey Year)   28b. Time of Injury	28c. Injury at 2 Work?	8d. Describe how	injury occurred	
Sio	endin eath. or: Af the fu	g	2 Accident investigation M	1 ☐ Yes 2 ☐ No			
Division	or Attend efter death Director:	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, street, factor building, etc. (Specify)	ory, office 2	8f. Location (Stree City or Town, S	et and Number or Rui Stete)	al Route Number,
	pital ours e eral C		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurre	d at the time, date and place, a	nd due to the caus	se(s) and manner as	stated
	24 h 24 h Fun letely	edicai	(Check only one)  2 Medical Examiner: On the basis of examination end/or investigation and manner stated.				
	To the Hospital or Attend within 24 hours efter death To the Funeral Director: completely filled in by the	Me		9c. License number		Date signed (Month	
	11		> Grafta GIAN, MD	19859855	J	ely 24.	2006
	15%		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	Dees 9855	2 /2		212211
	1- 1		21 Date film Haran Day Very	rge Ka, 1	patimo	ne MU	6/254.
	Sta Registr	10	31. Date filed (Month, Day, Year)  JUL 2 5 2006  22. Registrer's Signature				

			1 - For Stata Ragistrar	State of M	larylan		artmen rtificat					Rag. No.	006	232	74
	Physicia	an	1. Decedent's Name (First, Middle	ΛΛ			1/				Date of De     Month	ath Day	Year	3. Time of I	Death
	/Medic	al	GEORGE			Le		~			July	23	200	62'0	5 M
	Examin	er	4a. Facility Name (If not institution Augsburg L	utheran Ho	ome		4b. City,		Location o		(		ounty of Death		
	Funanal	-	5. Social Security Number			last birthday)	If Under		If Under		8. Date of Bir				Foreian
	Funeral Director		216-16-9821	1 <b>⊠</b> M 2□F	82	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Jan, 20	7, 7924	Mar	nplace (State or unity) yland	
	P.		Usual Residence of Decedent		1										
	show	_	MD Balt:	imore	10c. City	y, Town or Lo	ocation ltimo:	-						10d. Inside City 1 ☐ Yes	
	Be-f	ectc		LIIOLE		Da.						10- 011			
	be filed within 72 hours after death with the Maryland ital Hygiene d other than "natural", or items 23a or 28e-f show event, the Medical Examinar must be multified at	Funeral Director	10e. Street and Number 6811 Campfield	Road			10f. Zip	2120	07			_	n of What Co USA	untry	
	ns 23	era	11. Marital Status	12. Was Deceden	t Ever in U.	.S. 13.	Was Deced			igin? (Spe	cify Yes or No		Race - Ame	rican Indian,	
0	or Iter	Fun	1 ☐ Never Married 2 Marr	Armed Forces		1					cify Yes or No Rican, etc.)		Black, White	white	
3	ral', c	j Š	3 ☐ Widowed 4 ☐ Divorced	If Yes, Give Year or Dates:	:		1 Yes	2 <u> X </u> No	Specify:			Sp	pecify:	WIITCE	
215-0036	72 h	Completed by	15. Deceden (Specify only highes	t's Education st grade completed)		(Give	dent's Usua kind of wo	rk done a	luring mos	t of worki	ng		of Business/l	-	
2	vithin ne. han	m	Elementary/Secondary (0-12)	College (1-4or	5+)	Mec.	<i>po not us</i> hanica	al Di	, rafts	man		Eage	wood A	rsenal	
N	Hygie Hygie ther t	ပိ	12 17. Father's Name (First, Middle,	Last)					18. Mothe	er's Name	(First, Middle,	Maiden Su	mame)		
an	ad ala b	To Be	George Howard		Sr				_		ni Deit		/		
3	2 should be and Mental is marked of sumatic eve	-	19a_ Informant's Name/Relations			19b. Maili	ng Address	(Street a	and Numbe	er or Rura	I Route Numbe	er, City or To	own, State, Z	ip Code)	
Baltimore, Maryland 21	5 € Z = 1		Elsie Macauley-	-spouse		6811	Campi	field	Roa	d-Ba.	ltimore	,Mary	land 2	1207	
ore	0 0		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	3 DRemoval from State	20b. P	lace of Disponentery creating	osition (Nam	ne of they place	%1		ate	20c. Locat	tion - City or T Hill	Town, State	
Ĕ	Pages ment of i ant: If it		`4 □Donation 5 □ Other (S	pecify)	LVa	Bel 1	\ir_				5-06			,	
391	permit. Pag Department Important: f eny injury o		21. Signature of Funeral Service	Licensee	,		2. Name an			EVA	NS CHAP	EL OF	MEMOR	IES	
	<b>7</b> □ <b>2 6 0</b> 4		23a. Part1. Enter the disease, or	11/3-1000	4 100 400 1					ad-Pa	arkvile	,Mary	land 2	1234 Approximate	
			shock, or heart failure. List	only one cause on each	line.							11051,	:	Interval Betw Onset and D	reen
	Physician /Medical		disease or condition resulting in death)	a. One to (or as	e Br		Xu	to n	200	51-	<u>r</u>				
	Examiner			Due to (or as	s a consequ	derice or).									
		ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a consequ	uence of):									
	cate be executed physician and the burial-transit	Examiner	that initiated events	с											
Ď,	e exection a	EX	resulting in death) Last	Due to (or as	s a consequ	uence of):									
09/8	cate b	dicai		d											
9 ×	leath certifics attending ph I for use as th	Physician/Me	IF FEMALE:	23c. If yes, outcome	e of pregna	incy						224	I. Date of deli	ven/	
Rox	death e atten	ciar	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No	1 ☐ Live birth 4 ☐ Pregnant a			∃Ectopic pr ∃ Other (sp						Month	-	ear
o.	at the de by the a stached f	hys	9 Unknown	9□ Unknown											
ώ.	law requires that the as been signed by th 2 should be detache	by P	Part II. Dther significant condition	ons contributing to death	but not resu	ulting in the u	nderlying c	ause give	n in Part I.		23e. Did to	obacco use	contribute to	the cause of de	eath?
Vital Records,	w require been si should b										10	Yes 250	√o 3∏Pro	bably 4 Ur	nknown
ပ္ပိ	e law r has be je 2 sh	pie									24a. Was autop	an 2	24b. Were au	topsy findings a ompletion of ca	vailable use of
<u> </u>	Thate ate	Completed									1 Yes	rmed?	death? 1 🗌 Yes	2 🗆 No	
Ž	icien certifi rector	Be	25. Was case referred to medical examiner?	Hospital:				Othe	r .		(Check only o				
	Phys r this ral di	<u>۲</u>	1 Yes 2 No 27. Manner of Death	28a. Date of Inj		28b. Time of		A	4 1 NU		ne 5 Residence 128d. Describe 1			ify)	
0	Attending Physicien: If death. ector: After this certific by the funeral director.	tion	Natural 5 ☐ Pendin	XNatural 5 Pending (Month, Day Year) Injury Work?											
Division of	Atter	ifica	3 Suicide 6 Could of determined	singer   288. Place of It	njury - At ho	ome, farm, st	reet, factory	, office		- 1	28f. Location (S City or Tox	Street and N	lumber or Ru	ral Route Numb	er,
ā	i Qift o	Certification;	- I Torricos	building, e	( <i>apacit</i> )						Chy or rov	, Jiaitij			
	To the Hospitel within 24 hours a To the Funeral I completely filled	edical	(Check only 2. Medical	ng Physician: To the besi Examinar: On the basis	of examinat	wiedge, deat tion and/or in	h occurred vestigation.	at the tim	e, date an pinion, dea	nd place, a	and due to the	cause(s) an date and pla	d manner as	stated. to the cause(s)	
	To the hwithin 24 To the F complete	Med	one)  29b. Signature and title of certifie	and manner s	tated.		-						igned (Month		
	5 1 × 5	_	200. Signature and the or certifie	12ha	1_		230	1/1	ce.	7	,	20	> 6	7 m	•
1	XX		30. Name and address of person	who completed cause of	death (Item	23a) (Tune	Print	WI	10	12		viny		000	
Y	)			BOB MD	25	Ma	in	She	ed	2	1130	6			
	Sta		31. Date filed (Month, Day, Year)	82. Regist	frar's Signa	ture	E.				21134				
	Registr	ar	911 05 29	IIIh Allenda	1 54	No. of									

			For	State of Marylan	d / Depa	artment of h	Health and Me	ntal Hygiei	ne	00075
			1 = State Registrar		Ce	rtificate of		Reg.	No. 2006	23275
	Physicia /Medic		Decedent's Name (First, Middle, La     RUTH		MAC	MURK	RAY.	Date of Death Month	Day 2006	3. Time of Death
1	Examin	er	4a. Facility Name (If not institution, giv	re street and number)	1741	4b. City, Town, o	or Location of Death  ALTIMOR	E	4c. County of Death	/ Δ
	Funeral Director		5. Social Security Number 6. S 214-44-5935	Sex 7. Age (In yrs	last birthday) Yrs.	If Under 1 Year Months Days		Date of Birth (Month, Day, Ye		place (State or Foreign intry)
	/land		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Lo	ocation		~		10d. Inside City Limits
	deeth with the Maryland ima 23a or 28a-f show in nuat be notified at	Director	MARYLAND.	NIA			TIMORE			1 Yes 2 No
	with the	Dire	10e. Stréet and Number 2417 ED Mo	NOSON AVE	NUE	10f. Zip Code	2122	カ 10g.	Citizen of What Cou	intry?
	deeth Ima 23	Funeral	11. Marital Status	12. Was Decedent Ever in U		Was Decedent of h	Hispanic Origin? (Speci pan, Mexican, Puerto Ri	fy Yes or No-	14. Race - Ameri Black, White	
36	hours after deeth with the Marylan tural', or itams 23e or 28e-f show al Examiner must be nutified at	by Fu	1 ☐ Never Married 2 ☐ Married 3 ☑ Widowed 4 ☐ Divorced	1 ∐Yes 2 ☒ No If Yes, Give Year or Dates:		1 ☐ Yes 2 💆 No		Jan, 900.,	Specify:	DA 11
5-0036	n 72 hours • natural',		15. Decedent's E	ducation	16a. Dece	dent's Usual Occup	pation	16b	. Kind of Business/Ir	ndustry
121	within 7 ene. than 'n he Med	Completed	(Specify only highest gri	College (1-4or 5+)	life.	. 2	during most of working		aula)	HOME.
d 2			17. Father's Name (First, Middle, Last	)		TOME.	18. Mother's Name (	First, Middle, Maid		IONE
/land	Mental Mental Arked o	To Be	CHARLES	A.	BUT	75	JULIA	7	HOR	TON
Man	d 2 should be filed in and Mental Hyg 7 is marked othe traumatic event,		19a. Informant's Name/Relationship		19b. Maili	-10	t and Number or Rural I	Route Number, Ci	ty or Town, State, Zi	2
ē,	s 1 and f Healt item 2 other		KALPH MACMUR 20a. Method of Disposition	20b. F	Place of Dispo	Sition (Name of matory or other pla		19 200	Location - City r T	140,21223 own, State
Baltimore	Page ento nt: #		1 A Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci				CHRIST 08-0	1-06 5	UFFOLK,	VIRGINIA
Balt	Departm Departm mportal any inju		21. Signature of Funeral Service Lice	nsee	22	Name and Addre	H H BROY	UN JR.	FUNERAL	
			23a. Part1. Enter the disease, or comshock, or heart failure. List only	pplications that caused the deat	h. Do not en	er the mode of dy	ing, such as cardiac or		ALTO, ML	Approximate Intervat Between
	Pnysician		Immediate Cause (Final disease or condition	a C	Bri	mary	, Arte	ry De	seare	Onset and Death
1	/Medical Examiner		resulting in death)	Due to (or as a conseq	uence of):	1 d	then in in	/		
		Jer	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Oue to (or as a conseq	uence of):	ypur	-			
	be executed sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to (or as a conseq	ring	ary 1	ract.	freed	een	
760,	te be ex ysicien e burial	calE		d Tolleto	Aac	ral d	scubiter	s rela	ir	
68			IF FEMALE:							
.O. Box	The law requires that the death certificat ate hes been signed by the attending phy page 2 should be detached for use as th	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ▷ No 9 □ Unknown	23c. If yes, outcome of pregnation 1 Live birth 2 Feta 4 Pregnant at time of degree 9 Unknown	Ideath 3	Ectopic pregnanc Other (specify)	>y		23d. Date of deliv Month	rery Day Year
Q.	that the	by Phy	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause gr	ven in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
ords	w requires to been signed should be		Dialottes	mellita	4	Hypo,	Kallneg	1 🗆 Yes	2 No 3 Pro	bably 4 Dunknown
Division of Vital Records,		Completed	I'nlungr	via				24a. Was an autopsy performed 1 Yes 2	prior to co death?	opsy findings available ompletion of cause of 250 No
Vit?	ysician is certifi director	To Be	25. Was case referred to medicat examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 VInpatient 2	FR/Outcaties	1 3□ DOA   Ot	26. Place of Death (		e 6 □Other (Speci	(6 <i>t</i> )
n of	ding Phy h. After this funeral c		27. Manner of Death 1 ★Natural 5 □ Pending	28a. Date of Injury (Month, Day Year)	28b. Time o			d. Describe how it		'''
Sio	ttendir death. ctor: Ai	icatio	2 Accident investigation 3 Suicide 6 Could not t	De Diago of lawry At h	ome form et		Yes 2 □ No 28	f Location (Street	t and Number or Rur	ral Pouts Number
Div	al or A s efter il Direct	Certification:	4 Homicide determined	building, etc. (Special	(y)	eet, ractory, office		City or Town, S		ai moute mamber,
	To the Hospital or Attending Physician: within 24 hours efter death. To the Funeral Director: After this certific còmpletely filled in by the funeral director.	Medical (	29a. Certifier 1 Certifying P (Check only one) 1 Medical Exa	hysician: To the best of my knominer: On the basis of examination and manner stated.	owiedge, deat ation and/or in	h occurred at the ti vestigation, in my	ime, date and place, an opinion, death occurred	d due to the cause I at the time, date	e(s) and manner as and place, and due t	stated. to the cause(s)
	To the I	×	29b. Signature and title of certifier	0446	1	_	se number		Date signed (Month,	
	11		30. Name and address of person who	PHYSICIA	17V	Print)	57543	/	7-19-06	2
f	4		P. SANDAU, M	0 1940	W. BA	LTIMOR	RE ST, BI	ALTIMO	RE, MO	21223
	Sta Registi		31. Date filed (Month, Day, Year)	completed cause of death (Iter	ature.	pode	/			

			For State Registrar	State of M	Maryland /	-	artment of F		nd Mental H	ygiene Reg. No. 20	06 23276
			Decedent's Name (First, Middle	e, Last)					2. Date of I	Death	3. Time of Death
	Physici /Medio		Thomas Lewis M	organ, Sr.					July	18, <sup>Day</sup> 2006	8:00 P M
	Examir		4a. Facility Name (If not institution	, give street and numbe	er)		4b. City, Town, o	r Location of	Death	4c: County of	Death
			Home; 3939 Rola					timore		N/.	
	Funeral		5. Social Security Number 195–20–1167	6. Sex 7 ★XXM 2□ F	Age (In yrs. last bi	irthday) Yrs.	If Under 1 Year Months Days	If Under 2 Hours	Min. (Month, L	Day, Year)	Birthplace (State or Foreign Country)
	Director		Usual Residence of Decedent		75				March	19 <b>,</b> 1931	Pennsylvania
	yland		10a. State 10b. County	_	10c. City, Tov	vn or Lo	cation				10d. Inside City Limits
	Mar Miled	ctor	Maryland N,	/A		Balt	imore				XX Yes 2 No
	h with th	al Director	10e. Street and Number 3939 Roland Ave	enue Apt. 1	06		10f. Zip Code	2121	1	10g. Citizen of Wh	nat Country? USA
36	permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hyglene. Important: If Itam 27 le marked other than "natural", or Itema 23a or 28a-f ehow many njury or other traumatic event, the Madical Examinar must be notified at ance.	by Funerai	11. Marital Status  1 Never Married 2 Marr		s? ⊒No		Vas Decedent of Hi Yes, specify Cuba	ispanic Orig an, Mexican, Specify:	in? (Specify Yes or N Puerto Rican, etc.)	No- 14. Race - Black, Specify:	- American Indian, White, etc.
Ö	hour tural	d b	3 ☐ Widowed ♣️ Divorced		1948-52	Docor	lent's Usual Occup	ation			white
Maryland 21215-0036	within 72 ane. : Ihan "na a Medic	Completed	(Specify only highes Elementary/Secondary (0-12)	College (1-4c		(Give life. l	kind of work done of NOT use retired	during most	of working	16b. Kind of Busi	
д 5	Hygie Hygie other		12 17. Father's Name (First, Middle,	Last)			cretary	18. Mother	's Name (First, Midd		
<u>a</u>	lid be fental rked o	To Be	Samuel R. Morga	an				Marg	garet Mell	en	
Mary	end 2 should salth and Men n 27 le marke ler traumatic		19a. Informant's Name/Relationsi Patricia E. Moi				g Address (Street a Buchanan		or Rural Route Num ie Baltim	ber, City or Town, Store, Mary	
ře,	s 1 er	1	20a. Method of Disposition	_	nam ata	of Dispo	sition (Name of natory or other place	e)	Date	20c. Location - C	ity or Town, State
Ĕ	Pages nent of I ant: If Its ary or o		XX Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S)		" Maryl	and		Cemete	ery 7/25/0	6 Garriso	on Forest, MD
Baltimore,	permit. Pages Department of I Important: If Its any njury or of		21. Signal Funeral Service	- Carpent		22 E	Name and Addressurgee-Hei	ss of Facility	eitz Funer Baltim	al Home,	Inc. land 21211
			23a. Part1. Enter the disease, or shock, or heart failure. List	complications that caus	sed the death. Do						Approximate Interval Between &
	Physician		Immediate Cause (Final disease or condition		(	المحا	divinu	(m)	1/000	Arrest	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or a	as a consequence	of	, 1	1110			1
п	LXammer	_	Sequentially list conditions,	t. Due to (ex-		Voto	uti	MI			1 mines
	ted nsit	Examiner	Sequentially fist conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	a to) of ebd	as a consequence	or):					
	icate be executed physicien and s the burial-transit	Xar	that initiated events resulting in death) Last	c. Due to (or a	as a consequence	of):					_
8760	e be (/sicient	dical		d							
9	tificat ig phy as th	led		7							
O. Box	The law requires that the death certificate be executed tte has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		2 Fetal death at time of death		Ectopic pregnancy Other (specify)			23d. Date of Month	
<u>я</u>	es that tigned by	Ď	Part II. Other significant condition	ens contributing to death	but not resulting i	in the ur	derlying cause give	en in Part I.	3		ute to the cause of death?
Ö	w require been sij should t	eted		1100311115	- (1)	7140	0.0			Yes 2 No 3	Probably 4 Unknown
II Records,		Completed							24a. Wa aut per 1 □ Yes	opsy formed? dea	re autopsy findings available or to completion of cause of ath?  Yes 2 \sum No
Vital	ysician: Th iis certificate director, pag	Be	25. Was case referred a medical examiner?	Hospital			104		of Death (Check only	one	
	Phys this ral dir	- T	1 Yes 21 No	Hospital: 1 ☐ Inpa 28a. Date of In		utpatien Time of	3 DOA Othe	4 🔲 Nurs	sing Home 5		
5	ding I h. After funer	盲	1 Vatural 5 Pending 2 Accident investig	g (Month, E		Injury	28c. Injury Work	rai (? Yes 2 □ N		how injury occurred	
Division of	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.	Certification:	3 Suicide 6 Could r 4 Homicide determine	28e. Place of I	njury - At home, fa etc. (Specify)	arm, stre			28f. Location	(Street and Number own, State)	or Rural Route Number,
	To the Hospital or A within 24 hours after To the Funeral Dirac completely filled in b	Medical C	29a. Certifier 1 Certifyin (Chack only 2 Medical I	g Physician: To the bes Examiner. On the basis and manner	of examination ar	e, death	occurred at the timestigation, in my op	ne, date and pinion, death	place, and due to the occurred at the time	e cause(s) and mann , date and place, and	er as stated. d due to the cause(s)
	To the within 2 To the complex	Me	29b. Signature and title of certifier	12 2			29c. License	number		29d. Date signed (/	Month, Day, Year)
	1		<b>)</b> //3	wan h	1)		1)2	227	189	7./2	1/06
6	td		30. Name and address of person	who completed cause of	(Item-23a)	(Typs.)	Print) W	) }	200 8	2.33-5	5 Brut
	Sta Registr		31. Date filed (Month, Day, Year)		strar's Signature	locu					

M. HWEll

			1 10430	State of Manual				•		
			For State	State of Marylan				vientai Hygie	ene 2006	23277
			Registrar		Cen	ificate of L	Jeath		. No 0 0 0	40411
	Physicia	an	1. Decedent's Name (First, Middle, Las	11 Adia				Date of Death     Month	Day Year	
	/Medic		Maruin Down		hell			July	20 2006	
	Examin	er	4a. Facility Name (If not institution, give	. 11	4	4b. City, Town, or	Location of Deat	h	4c. County of Dea	ith
			Union Memor			Baltimo	(l		10/4	
	Funeral		5. Social Security Number 6. S	7. Age (In yrs.		Months Days	If Under 24 Hrs. Hours Min.	"(Month. Day. Y	(ear) C	thplace (State or Foreign ountry)
	Director		211-52-1092	56	115.			Aug 16,1	949	V #
	and wand		Usual Residence of Decedent  10a. State 10b. County	10c. Cit	y, Town or Loc	ation				10d. Inside City Limits
	be filed within 72 hours after death with the Maryland all bygiene. All bygiene do ther than "natural" or items 23a or 28a-f ehow do other than "natural" or items 23a or 28a-f ehow event, it a Medical Examinar must be notified at	ö	MA LAN	1 21						1 Yes 2 No
	28a-i	Director	10e. Street and Number	H [Dal	timore	10f. Zip Code		100	. Citizen of What C	
	with Fe or	ត់	0 - 1-1	0.0				100		oditity:
	s 23	Funeral	2703 Ulman	12. Was Decedent Ever in U.	C 12 W	21215	annia Origina (C	Pagain Van er Na	US A	adona ladina
	er de	un I	11. Marital Status	Armed Forces?	.S. 13. W	Yes, specify Cubar	spanic Origin? (S n, Mexican, Puert	pecify Yes or No- o Rican, etc.)	Bleck, Whi	
36	s aft	by F	1 Never Married 2 Married 3 Widowed 4 Divorced	f*QYes 2 ☐ No If Yes, Give Year or Dates:	11	Yes 2No	Specify:		Specify:	1- 1/
21215-0036	hour tural	De la	15. Decedent's Ed		16a Decede	nt's Usual Occupa	ition	16	b. Kind of Business	Modusta
Ϋ́	n 72	Completed	(Specify only highest gra	de completed)	(Give k	ind of work done d O NOT use retired	uring most of wor	rking	D. KING OF BUSINESS	viridustry
7	withi	Ĕ	Elementary/Secondary (0-12)	College (1-4or 5+)	0.4	sician	'	6	utheran	Hospital
2 2	filed Hygi ther int,	ŏ	17. Father's Name (First, Middle, Last)		0-14	510101	18. Mother's Nar	ne (First, Middle, Ma		
Maryland	od o	Be C	11.	<i>(</i> )			Ni:	11.	11	
Ë	d Me d Me mark matic	ဠ	Hebert 11) UN  19a. Informant's Name/Relations p		10h Mailing	Address /Street a	und Alumber or Pi	iral Route Number, (	City or Town State	Zin Cada)
Z	d2s than 7 ls treus		A Malla Manual Control of the Contro	Brother	000	1001033 (507001 &	TO THE THE	rarriodie rediliber, c	ony or rown, state,	2/0 0000)
	1 an Heeli em 2 ther		20a. Method of Disposition	20h F	Place of Disposi	tion (Name of	OC HUR	Date 20	c. Location - City or	Town State
פַ	in it of or o		1 Burial 2 ☐ Cremation 3 ☐	Removal from State	emetery, cremi	atory or other place	9)	. 161		V
Ħ.	t. Partmer		4 Donation 5 Other (Specify	11100	well Far		reng 1/0		notherno	, va
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mental Hygiene.  Department of Heelih and Mental Hygiene.  Department if them 27 is marked other than "natural" or items 23a or 28a-1 show eny Injury or other treumatic event, its Medical Examinar must be notified at page.		21. Signature of Funeral Service Uten	S <del>80</del>	22.	Nama and Addres	s of Hacility CV	<b>~</b>	tarris Fun	,
_	au z • u		Jerry Harr	is		10 Reist			1timore	Md 21215
			23a. Party. Enter the disease, or com- shock, or heart failure. List only	plications that caused the deat one cause on each line.	h. Do not <i>e</i> nte	the mode of dying	g, such as cardiad	or respiratory arres	1.	Approximate Interval Between Onset and Death
	Physician		Immediate Cause (Final disease or condition	· Intracra	enial H.	emr/hage				4 days
	/Medical		resulting in death)	Due to (or as a conseq		-				
	Examiner		Sequentially list conditions,	b						
	<b>σ</b> =	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	uariou of):					
p	nd trans	Examiner	that initiated events	С.						
760,	te be executed ysician and he burial-transit		resulting in death) Last	Due to (or as a conseq	uence of):					
876	ate b hysic the b	ical		d						
Box 68	eath certificate ettending phy I for use as the	Mec	IF FEMALE:							
<u>ô</u>	tend tend	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta		ctopic pregnancy			23d. Date of de	
	Physicien: The law requires thet the death certifical this certificale has been signed by the ettending phyral director, page 2 should be detached for use as the	Physician/Medi	1 ☐ Yes 2 ☐ No	4☐Pregnant at time of d 9☐Unknown	eath 5 🗌	Other (specify)			Month	Day Year
<u>о</u> .	that the de led by the e detached f	P.	9 Unknown							
Ś	signed d be de	b	Part II. Other significant conditions of	ontributing to death but not res	ulting in the und	lerlying cause give	n in Part I.			o the cause of death?
ב	w require been signature	ted						1 Yes	2 1 No 3 P	robably 4 Unknown
ပ္ပ	hes be	ple						24a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
<u> </u>	The ate h page	Completed						performe 1 ☐ Yes 2	d?_ death?	s 2 No
<u>=</u>	ien: artific etor.	Be	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only one)		
~	nysic dire	To.	1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient 2	ER/Outpatient	3 DOA Othe	or: 4 🗆 Nursing H	lome 5 Residen	e 6 □Other (Spe	ecify)
0	neral	Ë	27. Manner of Death 1 ☑ Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at	28d. Describe how	injury occurred	
<u>ō</u>	ath. r: Af	atic	2 ☐ Accident investigation		,,		res 2 □ No			
Division of Vital Records,	Atte	tific	3 ☐ Suicide 6 ☐ Could not be determined	28e. Place of Injury - At he building, etc. (Specif	ome, farm, stre	at, factory, office		28f. Location (Stre City or Town,	et and Number or R	lural Route Number,
Ö	s after or safte	Certification:		January, Stor (Speed	,,					
	ospil hour uner ly fill		29a. Certifier 1 Certifying Ph	ysician: To the best of my kno niner: On the basis of examina	wledge, death	occurred at the tim	e, date and place	, and due to the cau	se(s) and manner a	s stated.
	To the Hospital or Attending Physicien: The I within 24 Hours after death.  To the Funeral Director: After this certificate he completely filled in by the funeral director, page	ledicai	one)	and manner stated.						``
	To t To t	Σ	29b. Signature and title of certifier			29c. License			. Date signed (Mon	
			Janeur Grexan	Ly, us		ATa4	38946	vesity pare, ND 2,2	July 20	2006
	1		30. Name and address of person who	completed cause of death (Iten	n 23a) (Type, P	rint) a	OLE UN	resign par	Kway	
	1		Janelle Mexand	er Uhrm Mem	widehos	21 la/	Baltoner.	CUB 2,2	18	7
	Sta		30. Name and address of person who Sonelle Meyerd 31. Date filed (Month, Day, Year)  JUL 2 5 2006	32. Registrar's Storia	ature 1000					
	Registr	ar	JUL 25 2000	of the same	-/					
DIII	MH 17 Rev 1/2	001								

Months

7. Age (In yrs. last birthday)

90 Yrs.

6. Sex 1 □ M 2 ☑ F

**Physician** /Medical Examiner

1 - For State Registrar

212-01-2600 Usual Residence of Decedent

**Funeral** Director

with the Maryland 10b. County 10c. City, Town or Location MARYLAND r than "natural", or iteme 23s or 28s-f show the Medical Examinar must be notified at Director BALTIMORE 10e. Street and Number 2807 death Funeral Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Baltimore, Maryland 21215-0036 δ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) HOMEMAKER 10th GRADE 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Pages 1 and 2 should be nent of Health and Mental EUGENE MILES BERTHA 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health ar Important: if item 27 is sny injury or other treu 2807 OAKCREST AVE BATTHORE, No. 21234 ce of Disposition (Name of Date 20c. Location - City or Town, State DWARD C, McCLUSKEY JRL 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State MORELAND MEN GARDEUS JULY 14,2006 PARKVILLE, M.D. 4 Donatio 5 Other (Specify) 21. Signa ure of Punera Pervice Line PAUL STELLA F.H. 7507 HARFORD RD. 21234 23a art 1. Enter the displace, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart if flure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) oronowy **Physician** /Medical Due to (or as a consequence of Examiner ement Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours attendeath.

To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director; page 2 should be detached for use as the burial-transit Due to (or as a consequence of); Division of Vital Records, P.O. Box 68760, Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ Nor 9 ☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 ☑ No 10 28a. Date of Injury (Month, Day Year) 27. Manner of Dellin 28c. Injury at Work? 28b. Time of Certification: 1 🗆 ural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Thomicide 1 - Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number 29b. Signature and title of certifier

10d. Inside City Limits 1 785 2 No 10g. Citizen of What Country? Race - American Indian, Black, White, etc. Specify: WHITE 16b. Kind of Business/Industry FIDDIS

9:30 PM

Approximate Interval Between Onset and Death

Year

8. Date of Birth

23d. Date of delivery Month Day

23e. Did tobacco use contribute to the cause of death?

1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown

24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 10 No

2 -NO

Other: 4 Narsing Home 5 Residence 6 Other (Specify)

28d. Describe how injury occurred

28f. Location (Street and Number or Rural Route Number, City or Town, State)

H0054424

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Cyrus Asadi, 20 E. Timonium rd. #209 Timonium, MD 21093

State Registrar

31. Date filed (Month, Day, Year) 32. Registrar's Signature 2006

			State of Mandan	d / Department of Health and M	
			1- State Registrar	Certificate of Death	ental Hygien 0 6 23279
-			Decedent's Name (First, Middle, Last)		Date of Death     3. Time of Death
8	Physicia /Medic		DIANNE . F. McC	LAIN	Tuly 23 2006 6:50PM
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	4c. County of Death
i api			1702 BALDWIN Mill RD.	FOREST Hi	11 HARFORD.
933	Funeral Director		5. Social Security Number 6. Sex 1 M 2 M 7. Age (In yrs. 58	Months Days Hours Min.	8. Date of Birth (Month, Day, Year)  9. Birthplace (State or Foreign Country)  Country
			Usual Residence of Decedent		Nov 23, 1947 MD.
	rylan show	_		/, Town or Location	10d. Inside City Limits
	8a-f	Director	MD HARFORD	FOReST HILL	1 ☐ Yes 2 1 No
	with the	Dire	10e. Street and Number	10f. Zip Code	10g. Citizen of What Country?
	eath na 23	Funeral	11. Marital Status 12. Was Decedent Ever in U.	2 1050 S. 13. Was Decedent of Hispanic Origin? (Spec	Cify Yes or No-
ပ္	or iten		1 Never Married 2 Married 1 Yes 2 100		Rican, etc.) Black, White, etc.
21215-0036	be filed within 72 hours after death with the Maryland hal Hyglene. Id other than "natural", or itema 23a or 28a-f show event, the Medical Examinal must be notified at	d by	3 Widowed 4 Divorced If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ ₩6 Specify:	Specify: White
5-(	"natu	Completed	15. Decedent's Education (Specify only highest grade completed)	<ol> <li>Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)</li> </ol>	16b. Kind of Business/Industry
21	within ene. than "	Juno	Elementary/Secondary (0-12) College (1-4or 5+)	CLERK	FOOD Chain
	Hygir other	Be C	17. Father's Name (First, Middle, Last)		(First, Middle, Maiden Sumame)
Maryland	vid be Mental irked ritc ev	To B	Charles Smith	LORRAIN	ne Cook.
lar	2 sho and h is ma		19a. Informant's Name/Relationship (Type, Print)	19b. Mailing Address (Street and Number or Rural	
	s 1 and 2 should Health and Men Item 27 is marke other traumatic		James . 6 Mc Clair III	1702 BALdwin Mill KD. FE	
Baltimore,	6 O		20a. Method of Disposition  1 Perial 2 Cremation 3 Removal from State	emetery, crematory or other place)	200. 200ation Oily of Form, State
Itim	- 분원급 .		4 □ Donation 5 □ Other (Specify) □ GA (	dens of Anith Cem. 7/2	8 106 Rosedale, MD.
Ba	Depa Impo any to		I Land m. Stills	22. Name and Address of Facility PAUL STELLA FUNEZAL 7577 harford RD. 15	Home, pri 2 a 1 to Ma 2 1034
	Beginner of		23a. Part. Enter the disease, or complications that caused the death shock, or heart failure. List only one cause on each line.	Do not enter the mode of dying, such as cardiac or	r respiratory arrest, Approximate Interval Between
	Physician			rtensive Heart	directe Gust and Death Gust and Death Gust and Death
9	/Medical		resulting in death)	ience of): A A	
	Examiner	<u>.</u>	Sequentially list conditions, if any, leading to immediate	My Hry Sten	11201
J	ted nsit	Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	and on a condition	
v.	be executed sician and burial-transit	Exar	resulting in death) Last c. Due to (or as a consequence of the consequ	uence of):	
1260	± × €	cal	d	· · · · · · · · · · · · · · · · · · ·	
89	The law requires that the death certificat sie has been signed by the attending phy page 2 should be detached for use as th	Med	IF FEMALE:		
Вох	ath ce	lan/	23b. Was decedent pregnant in the past 12 months?	death 3 Ectopic pregnancy	23d. Dale of delivery  Month Day Year
0	the a	Physician/Med	1  Yes 2  4 Pregnant at time of do	eath 5 ☐ Other (specify)	and the state of t
<b>Q</b>	that the dened by the a	y Ph	Part II. Other significant conditions contributing to death but not resi	ulting in the underlying cause given in Part I.	23e. Did tobacco use contribute to the cause of death?
Vital Records,	quires n signi	ed by	Sciture 21300	2005	1 Yes 2 No 3 Probably 4 Unknown
000	aw requir is been si 2 should i	Completed	JE144. C (21.01		24a. Was an 24b. Were autopsy findings available
Ä		EOX			autopsy performed prior to completion of cause of death?  1 Yes 2 No 1 Yes 2 No
/ita	Physician: Th this certificete ral director, pag	Be (	25. Was case referred to medical examiner?	26. Place of Death	
of	Physi rthis o	2	The same same same same same same same sam	ER/Outpatient 3 DOA Other: 4 Nursing Hom	
O	Jing After fune	tlon	27. Manner of Death 1 Manual 5 □ Pending 2 □ Accident investigation 2 □ Accident investigation	28b. Time of	8d. Describe how injury occurred
Division	or Attending after death. Director: After In by the fune	flca	3 Suicide 6 Could not be determined 28e. Place of Injury - At ho	me, farm, street, factory, office 2	8f. Location (Street and Number or Rural Route Number,
Ö	를 를 들	Certification:	4 Homicide determined building, etc. (Specifi		City or Town, State)
	Hospital 24 hours 8 Funerat I		29a. Certifier 1 Certifying Physicien: To the best of my kno (Check only 2 Medical Examiner: On the basis of examina	wledge, death occurred at the time, date and place, a	and due to the cause(s) and manner as stated.  ad at the time, date and place, and due to the cause(s)
	To the h within 24 To the F complete	Medical	one) and manner stated.  29b. Signature and title of certifier	29c. License number	
	<b>5</b> ₹ 5 8	-	230. Signature and times 2 ia2 Mi		29d. Date signed (Month, Day, Year) 7124 \ 2006
,			30. Name and address of person who completed cause of death (item	3 (1.33	
	U		EWY WILD MY POR	OI North Charles, 13	ralfimore, MD 21204
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signa	ture	
	Registi	1,190	JUL 2 5 2006	1 Spell	200 m
	MH 17 Rev 1/2	001			

ORIGINAL

			For State Registrar		State	of Marylar	-	artmen <i>tificat</i>					Reg. No.	000	Ŝ	232	80
91	Dhysiai		1. Decedent's Name (Fin	rst, Middle, Las	t)							2. Date of De Month	eath Day	Ye	ar ,	3. Time of	
	Physici /Medic		Shirley	Pea			Mersor					JULY	21		06	7.50	РМ
	Examin	er	4a. Facility Name (If not	4 .						Location of				County of D	4	110-	
			BALTIMORE  5. Social Security Numb			MEDICA  7. Age (In yrs.		G LE		If Under		9 Date of Bir	ANI	· • —		NDE	
	Funeral Director		216-28-733		" □ M 2 🖫 F	7. Age (iii yis.			Days	Hours	Min.	8. Date of Bir (Month, Da Nov • 22	ay, Year)	31	Countr	ice (State o	ar r oreign
			Usual Residence of Dec									210 1 2 2	-, 1)				
	rylan show			b. County		10c. Ci	ty, Town or Lo								100	d. Inside C	ity Limits 2∑No
	Ba-f s	cto		nne Aru	nde⊥ ———		Sever										
	vith ff	Funerai Director	10e. Street and Number					10f. Zip						en of What	Countr	ry?	
	s 23s	erai	P.O.Box 11		12 Was Dag	edent Ever in U	15 13 1		144	enanic Ori	igin? (Sne	ority Vec or N	U.S	• A • 4. Race - A	America	n Indian	
	ter de frem	Fun	11. Marital Status 1 ☐ Never Married	2□ Married	Armed F	orces?	i					ecify Yes or No Rican, etc.)		Black, W	Vhite, et	tc.	
920	urs at	by	3 ☐ Widowed 4 🗹		If Yes, G Year or D	ve		1 ☐ Yes	2€ No	Specify:			5	Specify:	Whi	te	
21215-0036	within 72 hours after death with fhe Maryland ene. than "natural", or ltems 23a or 28a-f show the Madical Examirer must be notified at	Completed		Decedent's Ed		)	16a. Deced	dent's Usua kind of wo	al Occupa	ation during mos	t of worki	na	16b. Kin	d of Busine	ess/Indu	ıstry	
2	ithin 19.	npie	Elementary/Secondar		College (		life. I	DO NOT us	se retired	)			_				
N	iled w tygiel her ti		17. Father's Name (First	t Middle (ast)			Cook			18 Moths	ar's Name	(First, Middle		taura	int		
anc	ntal H	Be c	Lemuel Jac											· ·			
Maryland	should nd Me mark matic	o	19a. Informant's Name/		ype, Print)		19b. Mailir	ng Address	(Street a			becca N Route Numb			te, Zip (	Code)	
Ma	nd 2 sulth ar		Mrs. Linda			aughter		-	-				-			-	
Ē,	s 1 ar		20a. Method of Disposit	ion		20b. I	Place of Dispo cemetery, crer				Ju1y			ation - City			
e E	Page ienfo nt: If		1 X Burial 2 □ Cr `4 □ Donation 5 □			Julia	en Hav			-	200		Glen	Burni	e.	MD	
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with fihe Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or Items 23a or 28a-f show any righty or other traumatic event, It a Madical Examiner must be notified at ances.		21. Signatur of Finer	Service Licen	see	401411	22	. Name an	d Addres	s of Facilit	ty Si	ngleto					Α.
<u>m</u>	8978		1 popular		-	7901911	1	Seco	nd A	venue	s SW	Glen B	urnie	, MD	210	61	
			23a. Part1. Enter the di shock, or heart fai	isease, or comp ilure. List only (	olications that one cause on	caused the dea each line.	th. Do not ent	er the mod	e of dying	g, such as	cardiac c	or respiratory a	arrest,		1	Approxima: Interval Bel Onset and	ween
	Pnysician	K 11	Immediate Cause (Fina disease or condition	al —	a COA	GULO	PATH	۲								Onset and	Death
	/Medical Examiner		resulting in death)		1.1	(or as a consec	_	4 51									
		Į.	Sequentially list condition	ons,	b. Due to	ORRAGE	FRO N	1 1/1	LK	210	AMC				-		
3	uted I Insit	Examiner	Sequentially list condition any, leading to immediate. Enter Underlyin Cause (Disease or injur	ng ny	W <sub>0</sub>	ARYNG		CAN	CER	. (	1991	4)					
ő	exection and ial-tra	Еха	that initiated events resulting in death) Last			(or as a consec	quence of):					1			=		
8760,	ite be executed lysician and he burial-transit	ical			d KT-	EROSC	LEROS	SIS.									
9	ntifica ng ph as th	Med	IF FEMALE:											-			
Вох	death certificate e attending phys d for use as the	an/I	23b. Was decedent pre in the past 12 mor		1 Live	utcome of pregn birth 2 ☐ Feta	al death 3	Ectopic pr					23	3d. Date of Month			Year
.o.	the all	Physician/Med	1 Yes 2 No	)	4□Preg 9□Unkr	nant at time of o	death 5	] Other (sp	ecify)	-		-				,	,
Δ.	requires that the de een signed by the a nould be detached f	Ph	Part II. Other significan	nt conditions of	ontributing to o	death but not res	sulting in the u	nderlying c	ause give	n in Part I	l.	23e. Did	tobacco us	e contribut	e to the	cause of	leath?
ecords,	uires signe	d by	•					, ,	J			1 🗆	Yes 2	No 3/6	Probat	bly 4 □	Jnknown
COL	> 0 0	Completed										24a. Was	s an	24b. Werr	autop:	sy findings	available
$\alpha$	The lav ate has page 2	duo					- 11-11						ormed? 2 \( \subseteq \text{No} \)	prior deatl 1 🔲 ۱	to com	pletion of d !□ No	ause of
Vital	ician: Th certificate rector, pag	a	25. Was case referred t	to medical						26. Place	e of Death	1 Types			165 2		
<u>&gt;</u>	d is	ToB	examiner?		Hospital: 1X	Inpatient 2	ER/Outpatier	it 3 DC	Othe	9r: 4 □ Nu	ursing Ho	me 5 Res	idence 6	Other (	Specify)		
0			27. Manner of Death Natural 5	Pending	28a. Date (Mor	of Injury oth, Day Year)	28b. Time of Injury	2	8c. Injury Work	at c?	1	28d. Describe	how injury	occurred			
Sio	Attending r death. sctor: After oy the fune	catic	2 Accident	investigation				М	1 🗆 '	Yes 2□	-						
Division of	or Att	Certification:	3 ☐ Suicide 6 4 ☐ Homicide	determined	28e. Plac	e of Injury - At h ding, etc. (Speci	nome, farm, str ify)	eet, factory	r, office			28f. Location ( City or To	(Street and wn, State)	Number o	r Rural i	Route Nun	iber,
7	pital		29a. Certifier	Certifying Ph	vsician: To th	e best of my kn	owledge death	n occurred	at the tim	ne date an	nd place	and due to the	Cance(c) a	and manne	r as sta	tad	
1	24 hc 24 hc Fun etely	edical			iner: On the I	basis of examination											;)
٧	To the Hospital or Attenc within 24 hours after death To the Funeral Director; completely filled in by the	Me	29b. Signature and title	of certifier						number			29d. Date	signed (M	ion <i>th, D.</i>	ay, Year)	
	0		126	MAA				D	00	585	80		07/	25/	06		
	5			of person who	completed cau	use of death (Ite	m 23a) (Type,	Drint)				2011	-	-			
	J		BAI KAN		33 SU	PERIOR	LN P	21.	DU W	LL,	(117	20719	>				
	Sta Regist		31. Date filed (Month, I	UL 25	2006	PERIDR Registrar's Sign	ature	mark	1								
	negisti	all		- m	A.	0.40											

		Plea	ase Type or F					•			0.000
		For State Registrar	State of	Mar	yland / Depa <i>Ce</i>	artment of F rtificate of		Mental Hy	/gien Reg. N	40 00 00	2328
16.5	÷ 3	Decedent's Name (First, Midd	ile, Last)					2. Date of D	eath		3. Time of Death
Physicia	n	William	Edw	ord		Magalea	Too	Month		ay Year	0 20 D M
/Medica						Meseke	Jr. or Location of Death	July		2006 c. County of Death	8:30 P M
Examine	er	4a. Facility Name (If not institution		_	. T						1 1
	94	Genesis Elder				Brook1	-			Anne Arui	
Funeral		5. Social Security Number	6. Sex 1 XM 2 ☐ F	7. Age (	(In yrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	(Month, D	irth a <i>y, Year</i>	9. Birthp	place (State or Foreign ntry)
Director		220-05-7994			86 Yrs.			May 26	, 19	020	MD
p ,	-	Usual Residence of Decedent		1	IOc. City, Town or Lo						0.4 1-114-03-11-11-11-
death with the Maryland ms 23a or 28a-t show fmust be notified at	_	10a. State 10b. Count			i i	ocation				1	Od. Inside City Limits
Ma ta	Director	MD Anne	Arunde1	1	Linthicum						1 ☐ Yes 2 ☐ No
or 28	ē	10e. Street and Number				10f. Zip Code			10g. C	itizen of What Cour	ntry?
3a o	<u> </u>	415 West Green	wood Road			21090			[]	J.S.A.	
ms 2	Funerail	11. Marital Status	12. Was Dece		er in U.S. 13,	Was Decedent of H	Hispanic Origin? (S	pecify Yes or N		14. Race - Americ	
	5	1 ☐ Never Married 2 🕅 Ma	Armed For					o Rican, etc.)		Black, White,	
I', or	٦	3 ☐ Widowed 4 ☐ Divorce	If Yes Giv	е		1□Yes 2∰No	Specify:			Specify: Wh	Lte
natural',		15 Decede	nt's Education		16a Dece	dent's Usual Occup	nation		16b	Kind of Business/In	dustry
n 72	<u>ē</u>	(Specify only high	est grade completed)		(Give	kind of work done DO NOT use retired	during most of wor	rking	100.	Kind of Odsiness/iii	dustry
withi	Completed	Elementary/Secondary (0-12)	College (1-	-4or 5+)							,
filed within 72 hours after Hygiene. other then "natural", or Ite ent, the Medical Examina	ပိ	17. Father's Name (First, Middle	( act)		Home	e Builder	18. Mother's Nan	na /Firet Middl		onstructi	Lon
d tail	Be										
2 should be filed within 72 he and Mental Hygiene. Is marked other than "naturaumatic event, the Mudical	ို	William E. Me						Carol S			
2 sh and and surr		19a. Informant's Name/Relation			19b. Maili	ng Address (Street	and Number or Ru	iral Route Numi	ber, City	or Town, State, Zip	Code)
and ealth n 27 ner tr	1	Mr. Edward L.	Meseke /	Son						e, MD 210	
of He		20a. Method of Disposition 1 ☐ Burial 2 X Cremation	2 Pomoval from 6	State	20b. Place of Dispo cemetery, cre	osition (Name of matory or other plai	ce) July	$y^{\text{Date}}$ 21,	20c. l	Location - City or To	own, State
Pages nent of I int: It It ury or o		4 □Donation 5 □Other (		State	Chesapeal	ke Cremat	-		St	evensvil]	e MD
. 5 2 3	1	21. Signature of Funeral Service	Licensee	7						eral Home	
Departition of the control of the co		1 mila	ilanus	1	101357	Second	Avenue SI	J Glen	Rum	ie, MD 21	061
· 2		23a. Part1. Exter the disease, of	or complications that ca	aused th	ne death. Do not en					10, 120 21	Approximate
· · · · · · · · · · · · · · · · · · ·		shock, or heart failure. Lis	st only one cause on ea	ach line.							Interval Between Onset and Death
Physician		disease or condition resulting in death)	a	175	SPHAGI	A				04	3 WESTS
/Medical Examiner			Due to (	or as a	consequence of);	11.016	111	1 - [	-1 ,	W. A	7
		Sequentially list conditions, if any, leading to immediate	b	01	consequence of):  OR VE	41000	HCCI	DENT	40	1 1/1	3 WELLS
D #	<u>=</u>	cause. Enter Underlying	Due to (	orasa	consequence of):			100	Va	NUV	
executed n and ial-transit	Examiner	Cause (Diseese or injury that initiated events	с					M	I/V		
	_ 1	resulting in death) Last	Due to (	or as a	consequence of):			211	<b>1</b> 1	VV	
death certificate be e attending physicie d for use as the buri	Ca		d				- 1	M.	11/	11	
iffica g ph as th	e e		=-3=					V			
ndin use	$\frac{2}{2}$	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, out			7-				23d. Date of delive	ery
death atte	Ca	in the past 12 months? 1 ☐ Yes 2 ☐ No				Dectopic pregnancy Other (specify)	у			Month	Day Year
y the	Physician/Medicai	9 Unknown	9□ Unkno	wn							
that the de led by the a detached t	مَ ا	Part II. Other significant condit	tions contributing to de	ath but	not resulting in the u	ndertying cause giv	ven in Part I.	23e. Did	tobacco	use contribute to the	ne cause of death?
signed be de	ò	PARK	INSON	2'	0150	ASIS.		10	Yes 2	20 No 3 Prob	ably 4 Unknown
w require	Completed	PARK STERNAL	CALC	0 =	- 1 - 0		4.0 - 0				
has t	흔	JIEKN ITC	PRACTU	RE	CORO	NARY	ARTER	Y 24a. Wa	psy	prior to co	psy findings available mpletion of cause of
The ate t	ĕ	DISEAS	E.					perf 1 ☐ Yes	ormed? 2 <b>X</b> N	death? o 1 ☐ Yes	2 No
initio ctor,	Be (	25. Was case referred to medic examiner?					26. Place of Dea	th (Check only	one)		
ysic lis ce dire	2	1 Yes 2 No	Hospital: 1 🗆 Ir	npatient	2 ER/Outpatie	nt 3 DOA Cth	ner: 4 Nursing H	lome 5 Res	sidence	6 ☐Other (Specif	y)
g Pt		27. Manner of Death	28a. Date o	of Injury h, Day	Year) 28b. Time o	f 28c. Injur Wor		28d. Describe			
uth. r: Aft	읉	1 □ Natural 5 □ Pend 2 ■ Accident inves	tigation JUNE	27	2006 UNICH	14	Yes 2 No	PASLEN	SER	- IN M	VA
Attending Physician: The law requires that the death certificate be in death.  •ctor: After this certificate has been signed by the attending physicis by the funeral director, page 2 should be detached for use as the bu	I C	3 ☐ Suicide 6 ☐ Could	not be 28e. Place	of Iniun	/ - At home, farm, st			28f. Location	(Street a	and Number or Rura	
after Dire	Certification:	4  Homicide	buildir	ng, etc.	(Specify)			City or To		NOWN	
spita ours seral fillec		29a. Certifier 1, Certify	ing Physician: To the	best of			me, date and place				tated.
To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate ha completely filled in by the funeral director, page	Medical	(Check only 2 Medica	I Examiner: On the ba	asis of e	xamination and/or in	vestigation, in my	ppinion, death occu	rred at the time	, date ar	nd place, and due to	the cause(s)
ithin o the	¥ e	29b. Signature and title of certif				29c. Licens	se number		29d. D	ate signed (Month,	Day, Year)
F 3 F 8	1	. //	1 1	1			o, ,		_	_	

State

BRIAN (
31. Date filed (Month, Day,

Registrar

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

WALLACE, MD

32. Registar's Signature

03/136

Kilbride Road Baltimore, Maryland 21236

2006

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Vear 1:58 P. Andrew J. McGowan July 19, 2006 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) University of Maryland Medical Center Baltimore If Under 1 Year If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth Month, Day, March 18, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number Months 1 MM 2□F 80 Pennsylvania 199-12-4666 Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County 1 Yes 2 No Moosic Pennsylvania Lackawanna 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code USA 18507 208 Thoreau Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married Specify: White 1 ☐ Yes 2 ☐ No Specify: 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Priest Church 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Andrew Joseph McGowan Catherine Mary Evans 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Gertrude C. McGowan/Niece 37 Lombardo Drive Wilkes-Barre Pennsylvania 18702 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State St. Mary's Cemetery 7/24/06 Hanover Twp. Pennsylvania 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Leonard J. Ruck, Inc. 5305 Harford Road Baltimore Maryland 21214 21. Signature of Funeral Service Licensee Allow mistura 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate rause. First linderlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy Day Month Year in the past 12 months? 1 Yes 2 No 4☐Pregnant at time of death 5 Other (specify) 9□ Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? underwent commany Anteny bypass with 1 🗌 Yes 2 0 No 3 Probably 4 □Unknown Aortic value replacement and Mitral Value repair on 24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No 24a. Was an 6/20106. HAS MYEICLY SPIRSTIC SYNDROME IS WEIL. 2 No 1 Yes Other: Hospital: 2 No 2 ER/Outpatient 3 DOA 4 ☐ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 1 Inpatient 28a Pate of Injury (Month, Day Year) 28b. Time of

Examiner ed by the attending physician and detached for use as the burial-transit P.O. Box 68760, Division of Vital Records, Hospital or Attending Physician: After t 24 hours after death. e Funeral Director: A

Physician/Medical

Completed by

Be

Medical Certification: To

Physician

Examiner

10a. State

Director

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Completed

**Funeral** 

Director

r then "natural", or items 23a or 28a-f ehov tre Medical Examinar nast be notified at

permit. Pages 1 and 2 should be filed within 72 hours after Department of Health and Mental Hygiene. Important: If item 27 is marked other then "natural", or item eny injury or other traumatic event. It a Martine is a supportant.

**Physician** /Medical

Baltimore, Maryland 21215-0036

/Medical

9 Unknown 25. Was case referred to medical examiner? 1 🗌 Yes 27. Manner of eath Natural 5 Pending investigation

2 Accident 3 Suicide

4 | Homicide

29a. Certifier

28c. Injury at Work? 28d. Describe how injury occurred

1 ☐ Yes 2 ☐ No 28f. Location (Street and Number or Rural Route Number, City or Town, State)

lertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Madical Examinar: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

6 Could not be

completed cause of death (Item 23a) (Type, Print)

Imore, MO

State Registrar 31. Date filed (Month, Day, Year)

29b. Signature and title of certifier

32. Registrar's Signature

ORIGINAL

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

DHMH 17 Rev 1/2001

within 2

			State of Manuard / Dans		•	•	
			For State of Maryland / Department   State of Maryland / Department   State	artment of Health and M rtificate of Death		2006	23283
			Registrar  1. Decedent's Name (First, Middle, Last)	incate of Death	2. Date of Death	No.C. U U U	3. Time of Death
	Physicia					Day Year	6:45PM
	/Medic Examin		Caroline Emily McCarty  4a. Fecility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	July 23	2006 4c. County of Death	
	LXamiii		Holly Hill Manor Nursing Home	Towson		Baltimor	. 6
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth (Month, Day, Ye	9 Rinth	place (State or Foreign intry)
Ш	Director		577-28-9696		May 6,	1922	" MD
	and **		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lo	ocation			10d. Inside City Limits
	Mary -f sh	tor	MD Baltimore Dundal	k			1 ☐ Yes 2 ☐ No
	h the	lrec	10e, Street and Number	10f. Zip Code	10g.	Citizen of What Cou	intry?
	23a c	Funeral Director	103 Center Place	21222		SA	
	tems tru	uner	11, Marital Status  12. Was Decedent Ever in U.S. Armed Forces?  13. V	Was Decedent of Hispanic Origin? (Spe If Yes, specify Cuban, Mexican, Puerto	cify Yes or No- Rican, etc.)	14. Race - Amer Black, White	
9	s afte	by Fi	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates:	1 ☐ Yes 2 ☐ No Specify:		Specify: Wh	ite
3	filed within 72 hours after death with the Maryland Hygiene. Hygiene. the first star of them "neturel", or items 23e or 28e-f show ant, the Maryles Exaction out the natified at any.		15. Decedent's Education 16a. Decedenting 15a. Decedenting 16a. Decedenting 16a. Decedenting 16a. Decedenting 16a.	dent's Usual Occupation	16b	. Kind of Business/li	ndustry
2	hin 72	ple	(Specify only highest grade completed) (Give Elementary/Secondary (0-12) College (1-4or 5+)	kind of work done during most of working NOT use retired)			
7	giene giene er the	Completed		ccounting Clerk		Healthca	re
and	ba file tal Hy d oth event	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name	(First, Middle, Maid	den Sumame)	
<u> </u>	should ba f and Mental H s marked of umatic ever	P	James B. Knowles	Emma Ja	ne Melcl		- Contain
<u> </u>	pernit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene.  Department of Health and Mental Hygiene.  By any injury or other traumatic event, the Musical Exaculter count be nutified at Apple.		, , , , ,	04 Larch Rd., W	-		
a)	1 and Healt tem 2					L S II • MD  Location - City or T	
9	ages ant of tt: If it		Burial 20 Cremation 3   Removal from State	Crematory 7-2	5-06	.1	347
annor	partme cortan injur			2. Name and Address of Facility Bra	dlev-As1	nton Fun	eral Home
ă	Per Imp Pany Pany			A, 2134 Willow			
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac of	r respiratory arrest,	44	Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition				Onset and Death
	/Medical Examiner		Due to (or as a consequence of):				V
	Examine		Sequentially list conditions, if any leading to immediate  b. Dysphagia  Due to (or as a consequence of):				1 month
	₽ v is	nine	Sequentially list conditions, if any, leading to immediate Cause (Disease or injury that initiated events	+	79	month	
	be exacuted sician and burial-transit	Examiner	that initiated events resulting in death) Last  C. Due to (or as a consequence of):		111001011		
20/	that the death certificate be execut ad by the attending physician and detached for use as the burial-tran	cal	d				
ĝ	The law requires that the death certificate te has been signed by the attending physoge 2 should be detached for use as the	Physician/Medl	US FEMALE				
X P P	th cer tendir or use	an/N		☐Ectopic pregnancy		23d. Date of deliv	ery Day Year
	e dea the at ned fo	sici	in the past 12 months? 1 ☐ Yes 2 No 9 ☐ Unknown  1 ☐ Yes 2 No 9 ☐ Unknown	Other (specify)			54, 764
Į.	w requires that the been signed by the should be detach		Part II. Other significant conditions contributing to death but not resulting in the u	inderlying cause given in Part I.	23e. Did tobacc	co use contribute to	the cause of death?
as,	signs d ba	d by	Diabetes type 2	, ,	1 ☐ Yes	2 □ No 3 □ Pro	bably 4 Munknown
Vital Records,	w requir been si should	ompleted	Coronary artery disease		24a. Was an	24b. Were aut	opsy findings available
Ž	The lav	dmo	COTOTION OF STATE		autopsy performed 1 ☐ Yes 2 🔀	prior to e	ompletion of cause of
g		e C	25. Was case referred to medical	26. Place of Death		10 10	200110
	Physicien: this certific al director,	To B	examiner? 1   Yes   2   No   Hospital: 1   Inpatient   2   ER/Outpatier	nt 3 DOA Other: 4 Nursing Ho	me 5 Residence	e 6 □Other (Spec	fy)
n or	ding Ph h. After thi funeral		27. Manner of Death 1 ★Natural 5 Pending 28a. Date of Injury (Month, Day Year) 28b. Time of Injury	Work?	28d. Describe how i	njury occurred	
Division	tendi leath. tor: A the fu	catl	2 Accident investigation	M 1 ☐ Yes 2 ☐ No	296 Loanting (Ctron	t and Number or Du	m / Courte Mumber
$\leq$	or At after of Dirac in by	Certification;	4 Homicide determined 28e. Place of Injury - At home, farm, stream of the building, etc. (Specify)	геет, тастогу, опісе	City or Town, S	t and Number or Rui tate)	ar moute ivumber,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funeral Diractor: After this certific completely filled in by the funeral director,	S E	29a. Certifier 1 Certifying Physician: To the best of my knowledge, deat	th occurred at the time, date and place,	and due to the cause	e(s) and manner as	stated.
	e Hos	edical	(Check only 2 Medical Examiner: On the basis of examination and/or in and manner stated.	ivestigation, in my opinion, death occurr	ed at the time, date	and place, and due	to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	29c. License number	29d.	Date signed (Month	
	1		Juna Gendelsman M.D.	D51454	すし	11y 24	, 2006
	h		30. Name and address of person who completed cause of death (Item 23a) (Type,		MO 011	093	
	2. E   C   C   C   C   C   C   C   C   C		1205 York Road & Suite 38	Lytherville .	MD 211	νη <i>-</i> >	
	Sta Registr		31. Date filed (Month: Day Year) 2005 32 Registrar's Signature	- Paris			

		-	For State Registrar	State of Maryl		irtment of He tificate of D			giene leg. No.	006	23285
			Decedent's Name (First, Middle, Last)					2. Date of Dea	ith	V	3. Time of Death
	Physicia		Walter L. McAda	ms				July 1	8. 200	Year )6	8:30P M
		Medical Watter L. FCAdams  Sury  4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of Death								nty of Death	
			Montgomery Hospice Casey House Rockville						Mor	ntgome	ery
	Funeral		5. Social Security Number 6. Sex		vrs. last birthday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birt (Month, Day	Year)	9. Birth	nplace (State or Foreign untry)
J.	Director	}	219-64-0592 X	5	2 Yrs.			Aug. 8	<b>,</b> 1953	3 Wash	nington, DC
	and w	1	10a. State 10b. County	10c.	. City, Town or Lo	cation					10d. Inside City Limits
	Mary	ō	Maryland Howard		Laurel						1 □ Yes 2 □ No
	the	Funerai Director	10e. Street and Number		Laurer	10f. Zip Code			10g. Citizen	of What Co	
	3a ol		9641 Glendower Co	urt		20732			United	1 Stat	-68
	death ms 2	ner		Was Decedent Ever i Armed Forces?	n U.S. 13. V	Vas Decedent of His f Yes, specify Cuban,	panic Origin? (Sp	ecity Yes or No-	14. F		rican Indian,
ဖ	after or its	3	1 XNever Married 2 ☐ Married	1 ☐ Yes 2 XNo If Yes, Give					Spe		a, atc.
9	filed within 72 hours after death with the Maryland Hygiene. the than "natural", or floms 23a or 28a-f ehow ont, the Medical Enath or must be coulded at	d by	3 Widowed 4 Divorced	Year or Dates:		Pu		can		Wh	nite
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2	within ne.	d L	Elementary/Secondary (0-12)	College (1-4or 5+)		ectrician				•	lation
N D	Hygie Hygie other		17. Father's Name (First, Middle, Last)		EIG		18. Mother's Nam	e (First, Middle,			acton
au	m U =	o Be	John McAdam	ıc			Flizabo	eth Lee	Simmor	10	
Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mendal Hygiene.  ie marked other then "neturel", or items 23a or 28a-1 show the marked other then "neturel", or items 23a or 28a-1 show the unatic event, the Medical Exarchise marked excellined at	ဥ	19a. Informant's Name/Relationship (Typ		19b. Mailin	ig Address (Street an					(ip Code)
Š	alth ar		John M. McAdams, J	r./Brother	1000	3 Manor P	lace. Fa	airfax.	Virgin	nia 2	22032
ē,	s 1 a f Hea item othe		20a. Method of Disposition	20	b. Place of Dispo	sition (Name of		Date 7 21,	20c. Locatio		
Ë	Page nent c nt: if rry or		1 ☐ Burial 2 X Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	Montgome	natory or other place; ery ium. Inc.	2006		Bethes	iđa. M	Maryland
Baltimore,	permit. Pages 1 and 2 should be Depertment of Health and Menta important: if item 27 ie marked eny injury or other treumatic es	1	21. Signature of uneral Service Licens	е	22	. Name and Address	of Facility Rob	pert A.	Pumphr		1 77 /
<u> </u>	88 58		1. 26mg/		100803 Bg	thesda-Ch	evy Chas laryland	se <sub>2081</sub> 4-	3501 <sup>557</sup>	Wisc	neral Home/ consin Ave.
П			23a. Part1. Enter the disease, or complications shock, or heart failure. List only on	cations that caused the decause on each line.	death. Do not ent	er the mode of dying,	, such as cardiac	or respiratory ar	rest,		Approximate Interval Between
,	Physician		Immediate Cause (Final disease or condition	Large Co	11 Lymph	oma					Onset and Death Months
	/Medical Examiner		resulting in death)	Large Ce	sequence of):	DOING!					
	LAGITITICS	_	Sequentially list conditions, b	Due to (or se a ook	nia incorrect fle						
	ted	nine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	200 10 (51 45 4 55)	iosquerios ory.						
	cate be executed physicien and ; the burial-transit	Examiner	that initiated events cresulting in death) Last	Due to (or as a con	sequence of):						
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ဖ	uficat g phy as th	ed						1770			
Вох	h cer endin r use	N/UE	230. was decedent pregnant	3c. If yes, outcome of pre		Ectopic pregnancy				Date of deli	•
B	Attanding Physician: The law requires that the death certificate be executed refeath. sector: After this certificete has been signed by the attending physicien and by the tuneral director, page 2 should be detached for use as the burial-transit	by Physician/Me	in the past 12 months? 1 ☐ Yes 2 ☐ No	4☐ Pregnant at time 9☐ Unknown		Other (specify)				Month	Day Year
<u>о</u>	at the	Phy	9 Unknown	Aribustian to donath but not	and the second second	- dashiina anusa siyas	s in Dort I	220 Did to	phagag uso o	antabuta ta	the cause of death?
	res tha signed be det		Part II. Other significant conditions con	inbuting to death but not	resulting in the u	idenying cause giver	im Patti.	1 🗆 1	_		
0	w require been si should	eted									
Sec.	e law has t	Completed						24a. Was autop		prior to o death?	topsy findings available completion of cause of
a F	r: Th icete r, pag		_					1 Yes	2 No	1 ☐ Yes	2 No
₹	sician	Be	25. Was case referred to medical examiner?	ospital:	2 ER/Outpatier	Othor	26. Place of Dea			011 (0	-w. TT •
ō	Phy r this aral d	. To	1 ☐ Yes 2 No  27. Manner of Death	28a. Date of Injury	28b. Time of	28c. Injury	at	ome 5 Resident			Hospice
o	th. : Afte	tio	1 X Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Yea	ir) Injury	M 1 □ Y	es 2 No				
Division of Vital Records,	Atter r dea ector by the	1100	3 Suicide 6 Could not be determined	28e. Place of Injury - building, etc. (Sp	At home, farm, str	eet, factory, office		28f. Location (S City or Tox		ımber or Ru	ıral Route Number,
ā	s after or s after or	Certification:	TOTAL COMMENT	building, etc. (5)	, , , , , , , , , , , , , , , , , , ,			City or 70			
	To the Hospitel or Attending Physician: The law within 24 hours after death.  To the Funeral Director: After this certificete has completely filled in by the funeral director, page 2		(Check only 2 Medical Examin	sician: To the best of my ner: On the basis of exam							
	thin 2 the mplet	Medical	29b. Signature and title of certifier	and manner stated.		29c. License	number	-	29d. Date sig	ned (Monti	h. Dav. Year)
	10 Vit		214 A	agnel							
	Q		30. Name and address of person who co		(Item 23a) (Tvne	Print) D424	52		July	20, 2	(006
	15		Chitra Rajagopal,		-	er Mill R	oad, Roc	kville.	Marv1	and	20855
	Sta	ite	31. Date filed (Month. Dav. Year)	32. Registrar's S	Signature	AM. I					
	Regist	ar	JUL 2 5 2006	32. Registrar's S	15 JAJA						

			For State	State of Mar	yland / Depa	artmen	t of H	ealth a		-	giene	GUUb.	23286
_	1 - State Registrar Certificate of Death  1. Decedent's Name (First, Middle, Last)										Reg. No.		3. Time of Death
	Physicia	an								Month	Day		
	/Medic	al .	William D. Nauton  4a. Facility Name (If not institution, give s	stroot and number)		4h City	Town or	Location o		July 1		006 County of Dea	12:25 P M
	Examin	ĢΙ	BAltimore-Washingto		r	G1en			n Death		1 .	ne Aru	
-			5. Social Security Number 6. Sex		I • (In yrs. last birthday)	If Under		If Under:	24 Hrs.	8. Date of Bi			
	Funeral Director		1 🖸	[M 2□ F 5	Ven	Months	Days	Hours	Min.	B. Date of Bi (Month, D Jan. 1	ay, Year) 7 10		thplace (State or Foreign puntry) ryland
			219-50-5312 <sup>2</sup> Usual Residence of Decedent	<u>J</u>	/	ll				oun. 1	, 1	7-7   11G1	
	yland		10a. State 10b. County		10c. City, Town or Lo	cation							10d. Inside City Limits
	Mar Med si	tor	Maryland Anne Aru	nde1	Pasadena								1 ☐ Yes 2 🛣 No
	death with the Maryland ms 23e or 28e-f show r nust be notified at	Director	10e. Street and Number			10f. Zip	Code				10g. Cit	izen of What Co	ountry?
	11 wi	al	7981 Tick Neck Roa	ıd		1	1122					ted Stat	
	r dea	Funeral	11. Marital Status	12. Was Decedent Ev Armed Forces?	ver in U.S. 13.	Was Deced If Yes, spec	ent of His	spanic Ori n, Mexican	gin? (Spe 1, Puerto	ecify Yes or N Rican, etc.)	0-	<ol> <li>Race - Ame Black, White</li> </ol>	
8	hours after turel', or Ite	by Fu	1 ☐ Never Married 2 💢 Married 3 ☐ Widowed 4 ☐ Divorced	1 XYes 2 ☐ No If Yes, Give		1 ☐ Yes	2 💢 No	Specify:				Specify: Wh	ite
9500-c	hours after death with the Marylan turel', or Items 23e or 28e-1 show al Examiner must be mulfised at	δ	15. Decedent's Edu	Year or Dates:	l 16a Daca	dent's Usua	al Occupa	ition			16b K	ind of Business	/Industry
င်	n 72	Completed	(Specify only highest grade	completed)	(Give	kind of wor	rk done d	uring most	t of worki	ing	100.10	mg 01 5 3 3 m 10 3 3	,
7	with ene. than	mc d	Elementary/Secondary (0-12)  11 years	College (1-4or 5+)	Tow Mo	otor (	Inara	tor			Mod	licon U	ardware Co.
0		Be C	17. Father's Name (First, Middle, Last)	II/ d	TIOW 125		уреца	18. Mothe	r's Name	(First, Middle	e, Maiden	Surname)	ai uwai e -⊌u •
		To B	LeRoy C. Nauton Si	•				Clar	а Е.	Reck1:	ine		
>	should ind Men s marke umetic	-	19a. Informant's Name/Relationship (Ty	oe, Print)	19b. Mailii	ng Address	(Street a	nd Numbe	er or Rura	l Route Numb	ber, City o	r Town, State, .	Zip Code)
Ž	to 12		Jacqueline I. Nauto	on (wife)	7981	Tick	Necl	c Roa	d Pa	sadena	, Mar	yland	21122
ē,	s 1 a othe		20a. Method of Disposition		20b. Place of Dispo cemetery, crei	sition (Nan	ne of ther place	9)		Date	20c. Lo	ocation - City or	Town, State
Ē	t. Pages 1 and the transmittent of Healt them 2 trent: If item 2 hinry or other		1 M Burial 2 □ Cremation 3 □ P  1 4 □ Donation 5 □ Other (Specify)	emoval from State	Glen Have				7-21	-2006	Gler	n Burnie	e, Maryland
Baltimore,	permit. Pag Department Importent: any injury o		21. Signature of Funeral Service Licens		3.6	2. Name an	D -	s of Facilit	у			D 4	
ñ	Per Per B		, T	Wayne Oct	erling 1	COULTY	Fort	Lynia	K FU	neral l	dome,	P.A.	21230
			23a. Part 1. Enter the disease, or complete control of the control	cations that caused the	he death. Do not en	ter the mod	e of dying	, such as	cardiac c	or respiratory	arrest,	ii y i me	21230 Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	0.04	acon i	210	0111		- 1	Onset and Death			
Ε.	/Medical		resulting in death)	Due to (or as a	consequence of):			y	1		w.		
	Examiner		Otially list and distant	mun	willia	1	WH	wes	rvs	1			
	- V1 -	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a	consequence of:	j.	14	10	7				
	ransi	Examiner	Cause (Disease or injury that initiated events		dialie	les	IV	ell	AU	۵			
Ď,	be executed ician and and burial-transit		resulting in death) Last	Due to (or as a	consequence of):								
_	0 % 0	llcal		l									
200	entific ling p	by Physician/Med	IF FEMALE:	20 If you system of	i nrannav								
ROX	ath or ttend or us	ian/	23b. Was decedent pregnant in the past 12 months?	3c. If yes, outcome of 1 ☐ Live birth 2	Fetal death 3	Ectopic pr						23d. Dale of de Month	livery Day Year
	ne de the a hed f	sic	1 ☐ Yes 2 No 9 ☐ Unknown	4□Pregnant at ti 9□ Unknown	me or death 5 t	Other (sp	өспу)						
J.	hat the deby detac	P.	Part II. Other significant conditions con	ntributing to death but	not resulting in the u	nderlying c	ause give	n in Part I.		23e. Did	tobacco u	use contribute to	o the cause of death?
dS,	signe signe	δ		<b>3</b>	•	, ,				1 🗆	Yes 2	□No 3 🕎 🖰	robably 4 Unknown
Vital Records,	w requires that the de been signed by the should be detached	Completed								24a. Wa		24h Wara a	utopsy findings available
ě	elaw hasl ge2s	Ig II								auto	opsy formed?	prior to death?	completion of cause of
a	r: Th									1 ☐ Yes		1 ☐ Yes	2 No
	sicien: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:	a FARIO		Othe	200	77.7	(Check only		o 🗆 Other (Co.	
ō	Phys rthis raldi	- To	1 Yes 2 No	1 Inpatien			28c. Injury Work	4 🗆 Nu		28d. Describe		6 ☐ Other (Spe ry occurred	icity)
Division of	ding h. Afte fune	tlon	1 Natural 5 Pending 2 Accident investigation	(Month, Day	Ye <i>er)</i> Injury	м		:? ∕es 2 🔲	No				
<u> 181</u>	deal deal ctor	fica	3 Suicide 6 Could not be	28e. Place of Injur	y - At home, farm, st	reet, factory	y, office						ural Route Number,
Š	after Dire d in b	Certification:	4  Homicide	building, etc.	(Ѕреспу)					City or re	wn, State	9)	
	To the Hospitel or Attending Physicien: The law requires that the death certifical within 24 hours after death.  To the Funerel Director: After this certificate has been signed by the attending phycompietely filled in by the funeral director, page 2 should be detached for use as the	Salc	29a. Certifier (Check only 2 Medicel Exemi	sician: To the best of ner: On the basis of e	my knowledge, deat	h occurred	at the tim	e, date an	d place,	and due to the	cause(s)	and manner as	s stated.
	n 24 he Fu	edical	one)	and manner state						ou at the time			
	To t Withi To t	Σ	29b. Signature and title of certifier	Λ.	1.	290	c. License		17		29d. Da	te signed (Mont	n, Day, Year)
			tours	" allu	My AY	0		216			11	7410K	
	EXI		30. Name and address of person who co	mpleted cause of de	ath (Item 23a) (Type,	Print)				10.	٠١	1.05	21172
	J , .		Logare MDQ	11EX 0	2414 MA	goth	X K	203	NE	CIFE	1301	ena m	7/9/16
	Sta		31. Date filed (Month, Day, Year)	11	's Signature	ande	J			V		,	
	Regist	a!	1111 2 5 200	O Red Market	D 300	- do-							

7:55 а.ш.

		1 - State Registrar		C	ertificate	of Deatl	h	Re	g. No.			
		1. Decedent's Name (First, Middle, La	st)				2	. Date of Deat	h	· · · · ·	3. Time of	Death
Physi		Shirley Faye	Nestor					Month July	21 20	006	7:55	A M
/Med Exam		4a. Facility Name (If not institution, giv	e street and number)		4b. City, Tov	wn, or Location	n of Death		4c. County	of Death	_	
		Stella Maris Hos	pice		Tin	nonium			Balt	imore	е	
Funera	ıl	Social Security Number     6. S	ex 7. Age	(In yrs. last birthda	y) If Under 1 Y Months D	ear If Unde	er 24 Hrs. 8	. Date of Birth (Month, Day,	Year)	9. Birthp Coun	lace (State o	or Foreign
Directo	r	290-34-669/	LIM ZLALF	66 Yrs.			N	(Month, Day, Mar. 17	, 1940		Ohio	
pud *		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or	Location						0d. Inside Ci	ity Limits
aryla •ho	5	MD Howard		Laur							1 🗀 Yes	
he №	Director	10e. Street and Number		Laur	10f. Zip Co	-d-		44	Og. Citizen of V	Mh at Caus		
with a or	ă	8709 Cardinal Fo	rost Circl	0	101. 2ip Co	20723		, '	-	JSA	iuy:	
eath	Funerai	11. Marital Status	12. Was Decedent E		Was Decedent		Origin? (Specif	v Yes or No-		e - Americ	an Indian	
fler d	ᇤ	1 Never Married 2XXMarried	Armed Forces? 1 ☐ Yes 2 🕅 N	0	B. Was Decedent If Yes, specify	Cuban, Mexic	an, Puerto Rio	can, etc.)		k, White,		
within 72 hours after death with the Maryland within 72 hours after death with the Maryland than "neture!", or iteme 23a or 28a-f show he Medical Examiner must be notilified at	à	3 Widowed 4 Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X	No Specif	y:		Specity	Whi	te	
2 ho	Completed	15. Decedent's E	ducation	16a. Dec	cedent's Usual O	ccupation	ant of working		16b. Kind of Bu	usiness/Inc	dustry	
hin 7	] g	(Specify only highest gra Elementary/Secondary (0-12)	College (1-4or 5	+) life	ve kind of work a . DO NOT use r	etired)						
filed wii Hygien other th	Son	12th	Ø	Adm	inistra				Univers		of MD	
of 2 should be filed within 72 hours at the and Mental Hygiene. 77 is marked other than "neture!", or treumatic event, the Medical Exam	Be	17. Father's Name (First, Middle, Last,							Maiden Surnam	ie)		
2. Should be filed within 72 hours after death with the Marylan and Mental Hygiene. Is marked other than "neture!", or Iteme 23a or 28a-1 show eumatic event, the Medical Examiner must be notified as	ဥ	Alvin S. Baldwin		-		Rut	th Patt	on	_			
2 sh and Is m	4.7	19a. Informant's Name/Relationship (			iling Address (Si							
C - M F		James Nestor/Hus	band	Alexander Control	9 Cardi						20723	<b>,</b>
rmit. Pages 1 ac		20a. Method of Disposition  **X**Burial 2	Removal from State		ematory or other	r place)	Date		20c. Location -		,	
Pag ment: ant:		4 □Donation 5 □Other (Special	y)	Meadowr					Elkridg	•		
epart oport ny ln	ġ	21. Signature of Funeral Service Lices	1see		22. Name and A						e, P.A	
8055	a	pruceo	41 XXX	M01103	313 Tall					:0707		
		23a. Part1. Enter the disease, or com- shock or heart failure. List only	plications that caused one oause on each lin	the death. Do not e e.	inter the mode of	f dying, such a	as cardiac or r	espiratory arre	est,		Approximate Interval Bety	ween
Priysicia		fmmediate Cause (Final disease or condition	, PANCREAT	TIC CANCE	3					- 010	Onset and [	Jealii
/Medica Examine	_	resulting in death)	Due to (or as a	consequence of):								
Examine		Sequentially list conditions,	b									
sit sit	li ei	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of):						- 1		
ecute and -tran	Examiner	that initiated events resulting in death) Last	C. Due to /or as	a consequence of):								
cian cian buria			Due to (or as a	consequence on.								
ertificate be executed ing physician and e as the burial-transit	Medical		_d		100							
The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burial-transit		IF FEMALE:	23c. If yes, outcome	of pregnancy					024 D-1	6 -1-1		
eath ce attend for use	lan	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant at	2 Fetal death	Ectopic pregr				23d. Date Mor	e of delive nth	-	Year
that the de ed by the a	ysic	1 ☐ Yes 2 🔣 No 9 ☐ Unknown	9□ Unknown		Cition  specii	,,						
that ed by deta	by Physician	Part II. Other significant conditions	contributing to death bu	it not resulting in the	underlying caus	e given in Pari	t I.	23e. Did tob	acco use contr	ibute to th	e cause of d	leath?
uires sign d be								1 □ Ye	s 2 No	3 Prob	ably 4XJU	Jnknown
w requir been si should	Completed							24a. Was ar	24h V	Nara autor	osy findings a	available
ne lay a has ge 2	Ę			· · · · · · · · · · · · · · · · · · ·				autopsy	/ D	rior to con	npletion of ca	ause of
Attending Physicien: The Isr death.		25. Was case referred to medical			_			1□ Yes 2	No 1	☐ Yes	2□ No	
Attending Physicien: r death. ector: After this certific by the funeral director,	Be	examiner?	Hospital:	2 DED/D		D#		Check only one			посв	TOP
or Attending Physicien: The law requires I after death. Director: After this certificate has been signe in by the funeral director, page 2 should be of	. To	1 ☐ Yes 2 🔀 No 27. Manner of Death	28a. Date of Injur (Month, Day			Injury at			nce 6X Othe		) HOSP	LCE
Afte Tung	tion	1 XNatural 5 ☐ Pending 2 ☐ Accident investigatio		Year) Injury	м	Work? 1 ☐ Yes 2 [	_		,			
or Attendate death Director:	fica	3 ☐ Suicide 6 ☐ Could not b	e 28e. Place of Inju	ıry - At home, farm,	street, factory, of	fice	28f	Location (Str	eet and Numbe	er or Rura	i Route Num	ber.
after after din t	Certification:	4 Homicide	building, etc	: (Specify)				City or Town	, State)			
To the Hospital or A within 24 hours after To the Funeral Dire completely filled in b		29a. Certifier 1 ★ Certifying Pt	ysicien: To the best of	of my knowledge, de	ath occurred at t	he time, date a	and place, and	d due to the ca	use(s) and ma	nner as st	ated.	
HO HO Fu	Medical	(Check only 2 Medical Exer	niner: On the basis of and manner sta	examination and/or	investigation, in	my opinion, de	eath occurred	at the time, da	te and place, a	ind due to	the cause(s	)
To th To th	Me	29b. Signature and title of certifier			29c. Li	cense number	r	29	d. Date signed	(Month, (	Day, Year)	
di		1 /2			T	) 437	125		7/	21/0	16	
n		30. Name and address of person who	completed cause of de	eath (Item 23a) (Typ	e, Print)	( ) .	-		- 1			
12		DR. TARIO MAHMOO	DD 2300 DU	JLANEY VAI	LEY RD.	TIMO	NIUM, N	D 2109	3			
5	state	31. Date filed (Month, Day, Year)  JUL 2.5 201	35 Registra	r's Signature								
Regis	strar	1111 2.5 201	16 Beres	, S. A.	And Andreas							
DUMU 17 Day 1	10004	JUL	distribution of the second									

DHMH 17 Rev 1/2001

06-05180	
Diana Alberta Nelson	

Please Type or Print in Black Indelible Ink aryland / Department of Health and Ment State

		- For State registrar		Certificate of	f Death		R	eg. No. 2	005 2328			
Physiciai Medical Examin	n/ ,	1. Decedent's Name (First, Middle, Last)  2. Date of Death Month Da							3. Time of Death 1115 hrs			
ileulcai Laaiiiii		2 Maria Salaria Siason							4c. County of Death			
		2556 Barmesley Place Woodlawn							Baltimore County			
Funeral Director	- 1	5. Social Security Number 6. Sex	-	(Dlast birthday)	If Under 1 Year Months Days	If Under 24H Hours M	Irs. 8. Date of Bi	th(MM/DD/YYYY 3 <b>1956</b>	9. Birthplace (State or Foreign			
Director	-	3.00 00 110 1	1 2 X F —	Yrs			03/05	3 1956 5/ <del>1957</del>	Country) MD			
any		Usual Residence of Decedent 10a, State 10b, County	10c. (	City, Town or Locat	ion				10d Inside City Limits			
ž	١	MD Baltime	20	Voodlo	21.30				1 Yes 2 X No			
Maryland 28a-f show d at once.	Director	10e. Street and Number	711C 1 V	VOICE	10f. Zip Code	_	1	0g Citizen of Wh	nat Country?			
ith the Maryland 23a or 28a-f sho notified at once		2556 Parmesi	ley Place		2124	4		USA				
th with	<u></u>	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever i Armed Forces?	If Y	as Decedent of Hisp es, specify Cuban,			14. Race White	- American Indian, Black, e, etc.			
0	1	3 Widowed 4 Divorced	1 Yes 2 N Yes, Give Year		Yes 2 No	specify:		Specify:	Black			
ours afi	g S	15. Decedent's Education (Specify only	or Dates:	1) 16a. Deceder	nt's Usual Occupati	on (Give kind o		16b. Kind of Bu	siness/Industry			
)36 thin 72 hc re. than "ns edical Ex	Completed	Elementary/Secondary (0-12)	College (1-4 or 5+)	, ,	ost of working life.		etired)					
21215-0036 uld be filed within 7 Mental Hygiene. marked other than cevent, the Medies	[ -	121H GRADE 3	l years	ACC	<u>ountan</u>		me (First, Middle,	Bowie	State University			
215- e filed al Hyg eed out	Be C	Fred Mckinney			-	Dorot	. 11 1	Marcen Surrizine)				
ID 21215-0C should be filed win and Mental Hygien is marked other natic event, the Manatic event even		19a. Informant's Name/Relationship (Typ	4	19b. Mailin	g Address (Street		1/ 1001	nber, City or Tow	n, State, Zip Code)			
e, MD  I and 2 sho Health and Health and rem 27 is	L	Kimberly Elisa		4213	Chestnut	Lith	onia, G	A 300.	38 City or Town, State			
E = 2 %		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	crematory or ot		·   ,	Date	1				
[ 등 절 을 을 크.	-	4 Donation 5 Other Specify: 21. Signature of Funeral Service License	](	treenme	truct	of Equility	25/2006	Baltin	Dre, MD			
Balt permit. Depart Impor	ŀ	6 0 0	rone.	100	Name and Address	reene F	Funeral S	MC 217				
Physician	$\forall$	23a. Part I. Eriter the disease, or complice failure. List only one cause on each	ations that caused the de									
/Medical Examiner		Immediate Cause (Final disease a	Hypertensive a	theroscler	otic cardic	vascular	disease		Death			
ÇXAIIIIIOI		or condition resulting in death)	ue to (or as a consequent	ce of):								
	틸		ue to (or as a consequen	ce of):								
,	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	ue to (or as a consequen	ce of):								
		d										
e exe	n/Medical	X UNPENDED	AMENDED item#2		E,g857,7/27	7/06 TT						
20 to 12	ĬŽ	IF FEMALE: 3b. Was decedent pregnant in the	23c. If yes, outcome of p		etal death 3	Ectopic preg	ınancy	23d Date of Month	delivery  Day Year			
ox 6	sicia	past 12 months?  1 Yes 2 No 9 ✓ Unknown	4 Pregnant at time of	E al a a bla	ther (Specify)							
P.O. Box 687 s that the death certific gred by the attending p	Physicia	Part II. Other significant conditions	9 Unknown	not resulting in the	underlying cause of	ven in Part I.	23e. Did to	obacco use contri	bute to the cause of death?			
, P.O.	ģ	-	Ü	· ·	, , , ,		1 Ye	s 2 No 3	Probably 4 🗸 Unknown			
Division of Vital Records, tal or Attending Physician: The law requirers after death.  al Director: After this certificate has been sited in by the funeral director, page 2 should be	Completed				-	-	24a. Was		Vere autopsy findings available rior to completion of cause of			
Reco The law icate has	티						perfo	rmed? d	leath?  Yes 2 No			
tal Re(in)	Be C	25. Was case referred to medical			26 Place	of Death (Che						
Vital   hysician: this certifi	ટા	1 ✓ Yes 2 No	spital: 1 Inpatient 2		. 0 _ 00.1		sing Home 5	Residence 6				
n of V ding Phy n. After the		27. Manner of Death  1 X Natural 5 Pending	28a. Date of Injury (Month, Day,Year)	28b. Time of		y at Work? es 2 No	28d. Describe	how injury occurre	ed			
isior Attend ar death rector: by the	icati	2 Accident Investigation	28e Place of Injury -	At home, farm, stre			28f. Location (	Street and Numbe	er or Rural Route Number, City			
Division Spital or Attenchours after death meral Director:	Certification:	3 Suicide 6 Could not be determined	(Specify)				or Town, S	State)				
표 4 등 의			n: To the best of my know									
To the Hos within 24 h To the Fur completely	Medical	one) 2 Medical Examiner:	on the basis of examination and manner stated	on and/or investiga	29c. License		d at the time, date		ed (Month, Day, Year)			
	2	29b. Signature and title or certifier	100/1t	4	O.C.M			July 19, 200				
	+	30. Name a address of person who co	ompleted cause of death (	Item 23a)				1 , =, =				
Otoerd	1	·	sistant Medical Exa		Penn Street, B	altimore, M	D 21201					
Sta Regist	ate	31. Date filed (Month, Day, Year)	32. Rollstrar's Sig	nature	- 10							
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		1	For State Registrar		Marylan		artmen rtificat			ind M		Reg. No.	200	5	232	89
/Me	sicia: edica	1 I -	Decedent's Name (First, Middle, Last     Joseph H. Nosek     Facility Name (If not institution, give		hari		4h Cihy	Town or	Location of	f Death	July 23	, 2000	Ye		3. Time of Di 7:00 P.	
Exa	mine		Stella Maris Hospice				Tim	onium				E	Baltimo	re		
Fune Direct			214-10-7000	x ]M 2□F	87. Age (In yrs. I	Yrs.	If Under Months	Days	If Under 2 Hours	Min.	8. Date of Bin (Month Da June 10	1919	9.   M	Countr Birthpla Bryl	and	Foreign
Maryland			Usual Residence of Decedent 10a. State 10b. County  Maryland Baltimore			y. Town or Lo timore	cation							10	d. Inside City 1 ☐ Yes 🔰	
with the 3a or 28a		Die	10e. Street and Number 4102 Taylor Avenue Apt	. 315			10f. Zip					-	sen of What	Counti	y?	
permit. Pages 1 end 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important; if tiem 27 is marked other then "neture!", or iteme 23a or 28a-1 ehow any injury or other treamait to event. The Medical Experiment at the profited at		Dy rui	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Deced Armed Ford 1 1 Yes 2 If Yes, Give Year or Dat	es? □No WWI		Was Deced If Yes, spec 1  Yes		spanic Orig n, Mexican, Specify:	gin? (Spe , Puerto l	cify Yes or No Rican, etc.)		4. Race - A Black, V Specify: W	Vhite, e	ic.	
VICIONAL Within 72 ha Jiene. Tithen "netur The Medical		Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation le completed) College (1-4	4or 5+)	16a. Dece (Give life. Fire F	kind of wo DO NOT u	rk done a se retired	luring most	of workii	ng		imore C		ustry	
Mental Hygarked other		o ge C	17. Father's Name <i>(First, Middle, Last)</i> Stanislaus Nosek						18. Mother Anna S		(First, Middle, a	Maiden	Sumame)			
nd 2 sho alth and 1 27 is ma			19a. Informant's Name/Relationship (7) Joseph Nosek/Son	/pe, Print)		1	ng Address Westfi				i Route Numbe imore Mai				Code)	
Pages 1 enter of He out; If Item			20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specify,			tace of Dispo emetery, crer y Rosan				□ 7/27/	ate 06		nore Ma			
permit. Pages Department of Importent; If It	once		21. Signature of Funeral Service Licens	0. Wil-	ton	Le 53	Name ar opard 05 Har	d Addres J. Ru 'ford	s of Facility CK, In Road	C. Bålti	more Mar	vland	21214			
w requires that the death certificate be executed  we sequire that the death certificate be executed  which is the attending physicien and the should be detected for use as the burial-transit	eal ier	Ical Exa	23a. Part1. Enfer the disease, or comp shock, or heart failure. List only of the timediate Cause (Final disease or condition resulting in death)  Sequenfially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiate events resulting in death) Last	aCONGE Due to (o	ch line.  ESTIVE  r as a consequ  r as a consequ  r as a consequ	HEART uence of):									nterval Betwee	een eath
the death certific to the attending p		Physician/med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown		th 2∏Fetal nt at time of de	death 3	Ectopic pi Other <i>(s</i> p					2	3d. Date of Month		/ Day Ye	ar
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D Phys B Phys er this		0	27. Manner of Death  1 Natural 5 Pending 2 Accident investigation	Hospital: 1 In In 28a. Date of (Month	pafient 2  Injury , Day Year)	ER/Outpafier 28b. Time of Injury		8c. Injury Work	or: 4 🗆 Nur	rsing Hor	Check on cone 5 Residence	dence 6	· · · · · ·	Specify)	HOSP	ICE
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he Hosp in 24 hou ine Fune		edical	29a. Certifier (Check only one)  1X Certifying Phy 2 Medical Exam	iner: On the base and manner	sis of examina	wledge, deat tion and/or in	h occurred vestigation	at the tim , in my op	e, date and pinion, deat	d place, a h occurre	and due to the ed at the time,	cause(s) date and	and manne place, and	r as sta due to t	ted. he cause(s)	
Tot Tot	3	2	29b. Signature and title of certifier				290	License	number				signed (M) $\frac{7}{2}$			
15		-	30. Name and address of person who o		of death (Item			), т	TMONT	TIM	MD 2109		1	1		
Reg	Stat sistra	9	31. Date filed (Month, Day, Year)  JUL 2 5 20	32. Ri	bistrar's Signa		nach.	,	HORL	.0119	.w 210	, ,				

DHMH 17 Rev 1/2001

7:00 р.ш.

JULY 23, 2006

JOSEPH NOSEK

State of Maryland / Department of Health and Mental Hygiene 🤈 🗎 State Registramend #18 Per FH G857 7/25/06 Graphicate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day Month Donald James O'Brien Physician July 19, 2006 3:20 P. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Baltimore County Gilchrist Center Towson If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Ye NOV • 27, 9. Birthplace (State or Foreign Country), 1959 Washington, D.C 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 1 M 2 ☐ F **Funeral** Days Hours Months 46 220-76-0593 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City. Town or Location 10a. State 10b County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or items 23a or 28a-1 show early injury or other treumatic event, the Madical Examiner must be notified an once. 1 Yes 2 No Maryland Baltimore County Cockeysville Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21030 United States 4 Warwick Mill Court Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ 2 No If Yes, Give Year or Dates: 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2XXNo Specify: Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hampton Automotive College (1-4or 5+) Elementary/Secondary (0-12) Auto Tech. 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Lou Etta <del>Rita Reagan</del> **Therese** John Barton O'Brien 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 4 Warwick Mill Court, Cockeysville Maryland, 21030 Mrs. Pamela J. O'Brien (Wife) 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 ☐ Burial 2X Cremation 3 ☐ Removal from State Evans Funeral Chapel July 21,2006 Forest Hill, Maryland 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility 21. Signature of Funeral Service Licensee eaceful Alternatives Funeral&Cremation Ctr.,P.A. 2325 York Road, Timonium Maryland, 21093 Scela of Lebrum 23a. Part1. Enter the dilegie, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) weeks Physician /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Examine physicien and s the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Completed by Physiclan/Medical as the ed by the attending detached for use as 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 3 Ectopic pregnancy Year Month Day 4☐ Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☑ Unknown should should 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has the autopsy 1 Yes 2 No 1 ☐ Yes 2 ☐ No : After this certifical tuneral director, Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 No 1 Inpatient 2 ER/Outpatient 3 DOA ٩ 1 Tes 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Medical Certification: Natural 5 Pending s after de-ral Director: Att 1 Tyes 2 No investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) completely filled in by 4 Homicide 🕰 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certifier D58303 20 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6601 No Meales St Bortmore up Z1204 HARON COMPLES, UND 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 5 2006 Police

Registrar

Maryland 21215-0036

Baltimore,

certificate be executed

Box 68760

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Records,

of Vital

Division

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To the Hospital within 24 hours a Hospital

State of Maryland / Department of Health and Mental Hygiene 1 - State Registra Certificate of Death Reg. No. 2 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 2006 1130 AM Howard Lawrence Ochs, Sr. Tu /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Burnie Baltimore Washington Medical Conter Glen If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours Min 1⊠M 2□F 85 Director 212-18-3911 11-17-1920 MD Usual Residence of Deceden the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a State 10b. County 27 is marked other than "natural", or Itams 23s or 28s-f show traumatic event, the Medical Examinat must be notified at 1 ☐ Yes 2 No Anne Arundel Glen Burnie Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 end 2 should be filed within 72 hours after death with to Depertment of Health and Mental Hyglene.
Important: If Item 27 is marked other than "natural", or Itams 23e or 21 any injury or other traumatic event, the Mentals. 7 Wendover Road 21060 U.S.A. Completed by Funeral 14. Race - American Indian. 11. Marital Status 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Black, White, etc. 1 Yes 2 No 1 ☐ Never Married 21X Married Ochs, Howard Baltimore, Maryland 21215-0036 1 ☐ Yes 28 No Specify: Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Curtis Bay Towing Co. Elementary/Secondary (0-12) College (1-4or 5+) Deck Hand 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Mary Gertrude Holland George John Ochs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7 Wendover Road; Glen Burnie, MD 21060 Mrs. Doris M. Ochs / wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ⊠Burial 2 □ Cremation 3 □ Removal from State Glen Haven Mem. Park 📙 7-27-2006 Glen Burnie, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Puneral Service L 22. Name and Address of Facility Singleton Funeral Home, PA 1 Second Ave SW; Glen Burnie, MD 21061 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Cerebro Unscular Accident Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, bearing to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed burial-transit Due to (or as a consequence of): Box 68760, Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐ Pregnant at time of death 5 Other (specify) P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ģ page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 2 No 1 Yes Hospital or Attending Physicien: After this certifice funeral director, r 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: 1 npatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after deati To the Funeral Director: completely filled in by the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 29a. Certifier Scrifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) D027415 11 em 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) (enter, HENRY FRANCIS, M) As Melical Himore WAShington 32. Bigistrar's Signature 31. Date filed (Month, Day, Year) State 2006 Registrar

			1 - For State Registrar	State of Maryla	·	ent of Health and atte of Death		2000	23292
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	/Medic	al	4a. Facility Name (If not institution, give	street and number)	Ker 4b.cii	ty, Town, or Location of Deat	July 1	2000 4c. County of Death	2 pm
			Maryland Ges 5. Social Security Number 6. Se	reral HOS	a last birthday) If Und	elfmare ( der 1 Year   If Under 24 Hrs	8. Date of Birth	9/Birthr	place (State or Foreign
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	ryland how		Usual Residence of Decedent  10a. State  10b. County	10c. C	City, Town or Location			1	10d. Inside City Limits
	the Ma	Director	Naryand Number	<u>4</u>	Baltin	10re Zip Code	100	. Citizen of What Cou	1 Yes 2 □ No
	ath with s 23a or number		1802 N. Eu	taw St.		21217		USI	<u> </u>
9	hours after death with the Maryland turel', or Items 23a or 28e-1 ehow al Examinar must be rediffed at	by Funeral	11. Marital Status 1 Never Married 2 Married	12. Was Decedent Ever in I Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give	If Yes, sp	cedent of Hispanic Origin? (S pecify Cuban, Mexican, Puer 2 <b>[X</b> No <i>Specify:</i>	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
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	s 1 and 2 should f Health and Mer item 27 ie marke other traumatic		Mrs. Sonya	Smith	2928 Place of Disposition (A	Winches	ter St.	Balto.	Md. 21216
Baltimore	0 0 = =		20a. Method of Disposition   1 Burial 2 Cremation 3 4 Donation 5 Other (Specify,	Removal from State	cemetery, crematory o	r other place)	7/2006 7	c. Location - City or To	MA
Balti	permit. Pag Department Important: Imy injury once.		21. Signature of Funeral Service ocens	ee & R.	22. Name Josep	and Address of Facility	Funera	I Home.	P.A.
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lta!	ician: Th certificate rector, pag	Be Co	25. Was case referred to medical examiner?		Mille Company	26. Place of De	performe 1 Yes 2 dath (Check only one)	No 1⊡Yes	2□ No
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	To the within To the compl	Me	29b. Signature and title of certifier	44	2	29c. License number	290	. Date signed (Month,	Day, Year)
	7		30. Name and address of person who c	ompleted cause of death (Ite	om 23a) (Type Print)	89511		1/1//0	16
			Licia Tabata 31. Date filed (Month, Day, Year)	baeian, n	1, 0,90-	Marylane	d brene	ral Hos	prital
	Sta Registi		1111 2.5.20	ALC:	to Sparke	B			

Please Type or Print in Black Indelible Jak. Ensure All Copies Are Legible.
State of Maryland? Department of Health and Mental Hygiene

Certificate of Death

				1 - State Registrar		Ce	rtificate of	Death		Reg. No.	Jb	23293
_		Physici /Medic		1. Decedent's Name (First, Middle JEAN A. P					2. Date of D. JWThy	21 <sup>Day</sup> 200	6 <sup>rear</sup>	3. Time of Death 6:15 P <sub>M</sub>
		Examir		4a. Facility Name (If not institution Hart Herita	-		4b. City, Town, Stre	or Location of Deatle			of Death ford	
		Funeral Director		5. Social Security Number 113-30-1399	6. Sex 1 ☐ M 2X F	ge (In yrs. last birthday, 69 Yrs.	Months Days		8. Date of Bi	23,1937	9. Birthp Coun New	place (State or Foreign try) York
		death with the Maryland ms 23c or 28a-f ehow	tor	Usual Residence of Decedent  10a. State 10b. County  MD H	arford	10c. City, Town or L Bel Ai					1	0d. Inside City Limits 1 ☐ Yes ② No
		h with the 23c or 28s	<b>Funeral Director</b>	10e. Street and Number 1715 Gatehouse	Court		10f. Zip Code 210	14		10g. Citizen of V		ntry?
	920	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other then "natural", or itams 23c or 28a-1 ehow any injury or other treumatic event, the Marical Examination with a society.	by	11. Marital Status  1 □ Never Married 2 □ Marr 3 □ Widowed 4 🛣 Divorced	12. Was Decedent Armed Forces ied 1 Tyes 2 If Yes, Give Year or Dates:	2	Was Decedent of If Yes, specify Cui 1 ☐ Yes ※ No	Hispanic Origin? (S ban, Mexican, Puert Specify:	pecify Yes or N o Rican, etc.)		e - Americ k, White, Whi	etc.
/er	21215-0036	within 72 ho iene. • then "natur ihe Medical I	Completed	15. Deceden (Specify only higher Elementary/Secondary (0-12)	t's Education st grade completed)  College (1-4or	(Give	edent's Usual Occu e kind of work done DO NOT use retire trict Ma	e during most of wor ed)	rking	Verizon		ephone
Pool	land 2	uld be filed lental Hyg rked other ifc event,	To Be C	17. Father's Name (First, Middle, William Angie:					ne (First, Middle Connors	e, Maiden Suman	ie)	
>	, Mary	and 2 shoualth and N 27 is mail		19a. Informant's Name/Relations Kelly M.Botzle		19b. Maili 107	ing Address (Stree Colony P	at and Number or Ru lace-Bel	Air, Mar	per, City or Town, yland 21	State, Zip 014	Code)
Jean	Baltimore, Maryland	Pages 1 at the ment of He tent: If item		20a. Method of Disposition  1 Surial 2 Cremation  4 Donation 5 Other (S	pecify)	Ceme	h s Chur Lerv		Date 6-06		ld Sp	orings,New York
	Ball	permit Depart impor any in		21. Signature of Funeral Service	me fudd	3	2. Name and Adda Newpoi	ress of Facility rt Drive	NS FUN -Fores	VERAL C	HAPE Mar	L 21014 yland
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	68760,	sertificate be executed ding physician and se as the burial-transit	edical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	С	s a consequence of);						
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		iaw requires that the as been signed by th 2 should be detache	by	Part II. Other significant condition	ons contributing to death b	out not resulting in the t	underlying cause g	iven in Part I.				ne cause of death?
	Division of Vital Records,	sician: The law requir certificate has been si irector, page 2 should	Completed			<u>-</u> <u>-</u>			24a. Was auto perf 1 \( \text{Yes}	opsy ormed?	Were autoprior to condeath?	psy findings available inpletion of cause of
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•		To th within To th	W	29b. Signature and title of certifie	o su			3988	9	July		Day, Year)
8		10,		30. Name and address of person		death (Item 23a) (Type,	Delen	40.1 096				
		Sta Regista		31. Date filed (Month, Day, Year)		rar's Signature						

State of Maryland / Department of Health and Mental Hygiene 23294 Certificate of Death Reg. No. 2. Date of Death Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 1:02 A M Florence Theresita Palmer 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner HOSPITAL BALTIMORE 600D SAMARITAN If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day 12 07 Birthplace (State or Foreign Country) **Funeral** Days Min. 1 M XX Hours VA 64 229-58-8853 Director Usual Residence of Decedent the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28e-f ehow injury or other traumatic event, the Medical Examinar must be notified at 1X Yes 2 No Director Baltimore MD NA 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? ō or items 23a 21215 U.S.A. 3519 Liberty Heights Ave Funeral 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2**X** No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Specify: Black þ 3 Widowed 4 Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. important: If item 27 is marked other then "nal eny injury or other traumatic event, the Madaga 2006. Elementary/Secondary (0-12) College (1-4or 5+) Sinai Hospital 12th grade Nurses Aide na 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Bernice Holmes Edward Morris 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 19a Informant's Name/Relationship (Type Print) 3519 Liberty Heights Ave, Baltimore, Md Joseph Palmer-Husband 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Mt. Vernon Baptist Church Cemetery 7/29/06 White Stone, VA Signature of Funeral Service Licensee March F/H West 4300 Wabash Ave, Baltimore, Md 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death nmediate Cause (Final sease or condition sulting in death) **Physician** ANOXIC ENCEPHALOPATHY /Medical Due to (or as a consequence of) Examiner AND Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires thet the death certificate be executed Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🔼 No Month Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an certificete 2 No 1 Yes 1 Yes 2 🛛 No s after deam.

rai Director: After this cerus.

in by the funeral director, p. 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 XInpatient 2 ☐ ER/Outpatient 1 ☐ Yes 2 ☑ No 3□ DOA Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner. On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier W.GERGI 29b. Signature and tyle of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES 000 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600D SAMARITAN MARWAN UGERGI, 130 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

DHMH 17 Rev 1/2001

frome Palme

			For State	State of Maryland /	Department of Health and	d Mental Hygie	ne	00000
			Registrar		Certificate of Death	Reg	No. 2 U U D	23293
	Physici	an	1. Decedent's Name (First, Middle, La		PARKED	2. Date of Death	Day Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, giv	McKINLEY  a street and number)	4b City, Town, or Location of D	auth July 2.	4c. County of Death	p =
	Examir	ier	maryland Ger	1 - 1 / 1/10 0 /	l Bultmore	City	A)	1/2
	Funeral		5. Social Security Number 6. S	Sex 7. Age (In yrs. last i	birthday) If Under 1 Year If Under 24 I		9. Birthp	place (State or Foreign
	Director		245-30-0388	IXIM 2□F //9	Yrs. Months Days Hours A	Min. (Month, Day, You MARCH 15)	1927 NOR	TH CAROLINA
	pu ,		Usual Residence of Decedent	100 City To	own or Location	/	1.	Od Inside Obstinite
	aryla •hov	2	10a. State 10b. County	1 / A		0= 11.	2/	0d. Inside City Limits 1   Yes 2  No
	28a-1	Director	10e. Street and Number	114	25ALTIHO		Citizen of What Coun	1
	with	٥	1100 Provision	Addis AVE #12	19 210	201	1150	L.
	ne 23	Funerai	11. Marital Status	12. Was Decedent Ever in U.S.	13. Was Decedent of Hispanic Origin?	(Specify Yes or No-	14. Race - Americ	an Indian,
ယ္	or Her	표	1 Never Married 2 Married	Armed Forces?  1 Yes 2 No	If Yes, specify Cuban, Mexican, Po	uerto Rican, etc.)	Black, White,	etc.
5-0036	ral', C	d b	3 ¼ Widowed 4 □ Divorced	If Yes, Give Year or Dates:	1 ☐ Yes 2 ØNO Specify:		Specify: BL	ACK
5-0	within 72 hours after death with the Maryland ane. then "natural", or iteme 23e or 28e-f ehow he Madical Exercities tradities at	Completed by	15. Decedent's E (Specify only highest gra	ducation 16 ade completed)	Sa. Decedent's Usual Occupation (Give kind of work done during most of	working 16	b. Kind of Business/Inc	dustry
2121	within ane.	m	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	Δ	11-13-11-17-11-1	= 10
	Hygie Hygie ther ont, II		17. Father's Name (First, Middle, Last	(UNKNOWN)	MECHANIC 18. Mother's	Name (First, Middle, Ma.	den Sumame) [MA	INDUSTRY
Maryland	2 should be filled within and Mental Hygiene. Is marked other then aumatic event, the Mi	o Be	, , , ,		0 -	SCILLA		
<u>Z</u>	should nd Men marke	ပ္	19a. Informant's Name/Relationship (	Type, Print)	9b. Mailing Address (Street and Number of		ity or Town, State, Zip	Code)
Ž	1 and 2 Health a em 27 le		RITA PARKER	(DAUGHTER)	1913 N. BENTALO	UST, BAY	TIMORE M	021216
ē,			20a. Method of Disposition		of Disposition (Name of tery, crematory or other place)	4 4	c. Location - Cry or To	
Baltimore,	permit. Pages Department of Important: If I eny Injury or one		1 ⊠Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Special	IHAMOVALITOM STATE	DON PARKCEME 07	7-29-06 K	PALTIHORE	HARVI ANA
alt	permit. Pag Department Important: eny Injury c		21. Signature of Funeral Service Lice	199 A-	22. Name and Address of Facility		TR. FUNE	RAL HOME
<u>m</u>	89229			10m	2140 N. Ful	TON AVE.	BALTO,	4021217
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that caused the death. Doone cause on each line.	o not enter the mode of dying, such as care	diac or respiratory arrest		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	a. Preumonia	t e		- one property	Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence	7 (			
		-	Sequentially list conditions if any leading to immediate	Due to (or as a consequence	Fibrosis			
	nsit	Ë	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Asbestosis				
Ć,	execu n and ial-tra	Examine	that initiated events resulting in death) Last	Due to for as a consequence	ge of):			
8760,	icate be executed physicien and s the burial-transit	dicail		a Chronic Ok	structure Pulm	onary D	isease	
9	tificat ng phy as th							
Вох	leath certific attending p	an/	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea	ath 3 ☐ Ectopic pregnancy		23d. Date of delive	
-	the death certific y the attending p sched for use as	sici	in the past 12 months? 1 Yes 2 No	4☐Pregnant at time of death 9☐ Unknown	5 Other (specify)		Month	Day Year
P.0	at the	Physician/M	9 Unknown			20. 10:41.1		
	requires that the dei een signed by the a nould be deteched f	à	Lenge Failure		g in the underlying cause given in Part I.	1 ☐ Yes	co use contribute to th	./
Records,	req hou	Completed by	7,07000 101100			- (		
<b>3ec</b>	The law ate has b page 2 sl	mpi		** = 1		24a. Was an autopsy	24b. Were autop prior to con death?	psy findings available npletion of cause of
	n: Tł ficate x, pa		25. Was case referred to medical			performer	No 1 ☐ Yes	2 No
Ξ	Physician: r this certificinal director,	To Be	examiner?	Hospital:		Death <i>(Check</i> on <i>ly one)</i> g Home 5 ☐ Residenc	a 6 DOther (Specif	
<b>o</b>	g Phy er this		27. Manner of Death	<u> </u>	o. Time of 28c. Injury at	28d. Describe how		<u>//</u>
Ö	Attending r death.	atio	1 □ Natural 5 □ Pending 2 □ Accident investigation		Injury Work?  M 1 □ Yes 2 □ No			
Division of Vital	r Atte er de recto by th	Certification:	3 ☐ Suicide 6 ☐ Could not be determined		farm, street, factory, office	28f. Location (Stree City or Town, S	t and Number or Rura	l Route Number,
Ö	ital or /	Cer						
	Hosp 4 hou Fune ely fil	cai	(Check only 2 Medical Exa	miner: On the basis of examination:	lge, death occurred at the time, date and pl and/or investigation, in my opinion, death o	ace, and due to the caus ccurred at the time, date	e(s) and manner as st and place, and due to	ated. the cause(s)
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medicai	one) 29b. Signature and title of certifier	and manner stated.	29c. License number		Date signed (Month, I	
	N I I N		V A. la Tala	The hase	80 577	290.	1/23/16	-u, .ou/
L			30. Name and address of person who	completed cause of death (Itam 22	O70//		1100100	
7	)		Lida Tabata	baeian M.U.	To Maryland	General	l HOSOI	tal
	Sta	ate	31. Date filed (Month, Day, Year)	32. Pagistrar's Signature	And a	-,0,,0,0	- / - / - / - /	
	Regist	rar	1111 9 5 2	MAGINE D.	Charles of the Control of the Contro			

			For State Registrar	State of Ma	ıryland		artment of I tificate of		ınd Me		ene g. No. 20	06	23296
	Physici		Decedent's Name (First, Middle, Last)     Richard Joseph	n Pabst	, Sr.					2. Date of Death Month JULY		ž806	3. Time of Death 11:35 AA
7	/Medic Examin		4a. Facility Name (If not institution, give sint Joseph	treet and number)		ter	4b. City, Town,		Death	n	4c. County		imore
	Funeral Director	-	5. Social Security Number 6. Sex 1世	M 2□F		a <i>st birthday)</i> 82 Yrs.	If Under 1 Year Months Days	If Under 2 Hours	24 Hrs.   8 Min.	B. Date of Birth (Month, Day, AUG 23	Year) 1923	9. Birthpla Counti	ace (State or Foreign y) MD
	Maryland f ehow	ō	Usual Residence of Decedent  10a. State 10b. County  MD Baltimor	•e		Town or Lo						10	d. Inside City Limits 1 ☐ Yes 2 🛣 No
	with the Page of 28e-	I Director	10e. Street and Number 8162 Glen Gary Roa				10f. Zip Code 21234	4		10	g. Citizen of \		ry?
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heath and Mental Hygiene. Important: If Itam 27 is marked other than "natural", or Itame 23a or 28e-f show any fujury or other traumatic event, the Madical Extendent most be notified at anote.	by Funeral		2. Was Decedent E Armed Forces? 1 XYes 2 N If Yes, Give Year or Dates:	lo	li li	Vas Decedent of I Yes, specify Cub	an, Mexican	gin? (Spec , Puerto R	ify Yes or No- lican, etc.)	14. Rac	e - America ck, White, e	tc.
21215-0036	within 72 houlene. In mature	Completed	15. Decedent's Educ (Specify only highest grade Elementary/Secondary (0-12)	ation		(Give	lent's Usual Occu kind of work done DO NOT use retire	during most	of working	9	6b. Kind of B		ustry cation
land 2	uld be fited Aental Hygi rked other tic event, I	To Be Co	17. Father's Name (First, Middle, Last) Richard A. Pa	abst	1			18. Mothe H <b>il</b>		(First, Middle, M Dickie			
Mary	ulth and h	y :	19a. Informant's Name/Relationship (Type Katharine M. Pabst		ter		g Address (Stree Sycamore						21090
ore,	ages 1 an nt of Hea :: If Itam	3	20a. Method of Disposition 1 ☐ Burial 2 🏿 Cremation 3 ☐ Re		20b. PI	ace of Dispo emetery, cren	sition (Name of natory or other pla	ce)	Da	ite 2	0c. Location -	City or Tov	
Baltimore, Maryland	permit. Pa Departmen Important any injury		4 Donation 5 Other (Specify) 21. Signature of Funeral Service License	1-11-	Cn. M0098	22	ke Crema 3474,ª Str 3717 Gre	ephen Eacility	D. Lo	/2006 ohrmann, s Drive,	PA Towso		
	Physician		23a. Part1. Enter the disease, or complic shock, or heart failure. List only on Immediate Cause (Final disease or condition	e cause on each lin	Θ.			ng, such as	cardiac or	respiratory arre	st,		Approximate Interval Between Onset and Death
die o	/Medical Examiner		resulting in death)	Due to (or as a			RY DISE	ASE			· -		
<b>—</b>	ecuted and transit	Examiner	Sequentially list conditions, if any, teading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	TIA								
8760,	ficate be executed physicien and is the burial-transit	dicai	L	Due to (or as a	a consequ	Jenice Ory.							
.O. Box 6	death certi e attending ed for use a	by Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of 1 Live birth 4 Pregnant at 9 Unknown	2 🗌 Fetal	death 3	Ectopic pregnanc Other <i>(specify)</i>	У				te of deliver onth [	y Day Year
۵.	The law requires that the site hes been signed by the page 2 should be deteche		Part II. Other significant conditions con	tributing to death bu	ut not resu	ilting in the ur	nderlying cause gr	ven in Part I.			acco use cont	nbute to the	cause of death?
Division of Vital Records,		Completed								24a. Was an autopsy perform 1 Yes 2	ed?	prior to com death?	sy findings available pletion of cause of
Vita	Physician: Th this certificate rai director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No	ospital: 1 Minpatie	nt 2□I	ER/Outpatien	t 3 DOA Ot	har		(Check only one		er (Specify)	
ion of	To the Hospital or Attanding Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director,		27. Manner of Death 1 A Natural 5 Pending 2 Accident investigation	28a. Date of Injur (Month, Day	у	28b. Time of Injury	28c. Inju	ry at	28	Bd. Describe how			
Divis	tal or Attraction of Directors	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injubulding, etc.	ury - At ho c. <i>(Specify</i>	me, farm, str	eet, factory, office	STATE OF THE	28	Bf. Location (Stre City or Town,	eet and Numb State)	er or Rural	Route Number,
	Hospital     24 hours al     Funeral D     letely filled i	edical	29a. Certifier 115 Certifying Phys (Check only 2 Medical Examin	icien: To the best of er: On the basis of and manner sta	examinat	wledge, death ion and/or inv	n occurred at the t vestigation, in my	ime, date ani opinion, deat	d place, ar th occurre	nd due to the car d at the time, da	use(s) and ma te and place,	anner as sta and due to	ted. he cause(s)
	To the within 2 To the complet	Me	29b. Signature and title of certifier	mel	ita	mo	29c. Licen	se number		29	d. Date signe	d (Month, D	2 vi 6.
2	0 1		30. Name and address of person who con JOGINDER F. ME	mpleted cause of de			Print) OSLER	DRIVE	TOV	vson. N	1ARYLF	ND 2	1204
	Sta Registi		31. Date filed (Month, Day, Year)  JUL 2 5 200	32. Registra			arte			*			

		•	For State Registrar	State of N	Maryland / Depa		of Health an	d Mental Hy	giene Reg. No.2 () (	16	23298
2.	Physici	an	1. Decedent's Name (First, Middle, Las	t)				2. Date of De Month	Day	Year	3. Time of Death
	/Medic		Thelma		E.		Rose	July	22 20	06	214424
	Examir	er	4a. Facility Name (If not institution, give	street and numbe	(r)	4b. City, Tow	vn, or Location of D		4c. County	or Death	
			5. Social Security Number 6. Se	2501191	Age (In yrs. last birthday)	If Under 1 Y	ear If Under 24	Hrs. 8. Date of Bir	rth	9. Birthol	lace (State or Foreign
Ŧ	Funeral Director			_M 2 <b>X</b> ]F	84 Yrs.	Months Da	ays Hours I	Min. (Month, Da	ay, Year) 06 21	Coun	(ry) GA
	Mr. V		Usual Residence of Decedent						/ <u>U</u>		
	trylan show	_	10a. State 10b. County		10c. City, Town or Lo					10	0d. Inside City Limits  XXYes 2 □ No
	88-f	cto	MD NA		Baltimo				10= 02:634	/	
	with the	直	10e. Street and Number			10f. Zip Co	21216		10g. Citizen of V	Vinat Coun S • A •	try ?
	s within 72 hours after death with the Maryland liene r than "natural", or itema 23a or 28e-f show the Medical Examinar must be notified at	Funeral Director	2819 West Nort	n AVE 12. Was Deceder	nt Ever in U.S. 13.	Was Decedent				- Americ	an Indian,
10	fter d	F	1 ☐ Never Married 2 ☐ Married	Armed Force 1 ☐ Yes 💥	∃No			? (Specify Yes or No Puerto Rican, etc.)	Blac	k, White,	etc.
93	el'.o	þ	XVidowed 4 □ Divorced	If Yes, Give Year or Dates		1∐Yes 2 <u>K</u> J	No Specify:		Specify	В	lack
20	72 ho	Completed	15. Decedent's Ed (Specify only highest gra		(Give	dent's Usual O	lone durina most of	f working	16b. Kind of Bu	siness/Inc	lustry
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2			12th grade  17. Father's Name (First, Middle, Last)	na		rress		Name (First, Middle			
anc	ed at b	) Be	James Hughes					Haines	,	-,	
Maryland 21215-0036	2 should be and Menta is marked sumatic ev	ဥ	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (St	treet and Number o	or Rural Route Numb	er, City or Town,	State, Zip	Code)
	and 2		Grady Bridges-	Nephew	2819	West	North	Ave, Bal	timore	, Md	21216
Baltimore,	s 1 and 2 f Health itam 27 other tra		20a. Method of Disposition		20b. Place of Dispo	osition (Name o	of r place)	Date	20c. Location -	City or To	wn, State
Ë	Pages nent of int: if it		1 XBurial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		Arbutus	-		29/2006	Arbut	us,	Md
alti	permit. Pages Department of I Important: if its any injury or or once.		2). Signative of Funeral Service Licen	see 🕢	2:	2. Name and A	ddress of Facility				
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			23a. P. 11. Enter the disease, or comp s ock, or heart failure. List only	olications (that caus one cause on each	d the death. Do not en line.	er the mode of	f dying, such as car	rdiac or respiratory a	arrest,		Approximate Interval Between Onset and Death
	Physician	10	Imm diate Cause (Final dise se or condition	alesp	ratory!	Acid	0315				Criser and Death
	/Medical Examiner		resulting in death)	Due to ( r	as a consequenc	11 V	7/ /	\ -	_		
	- Ann	_	Sequentially list conditions,	b. Gas	as a consequence of):	etlet	Obst	ructio	( )	-	
	ted nsit	ᇤ	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	4011	astatic	Colo	OCA				
÷,	be executed ician and burial-transit	Examiner	that initiated events resulting in death) Last	Due to (or	as a consequence of):	000					
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9	The law requires that the death certificate te has been signed by the attending physoage 2 should be detached for use as the										
Вох	eath certific attending pl	an/N	tF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor 1 ☐ Live birth		Ectopic pregr	nancy			e of delive	,
	e dea he att	sici	in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	4□Pregnant 9□ Unknowr		Other (specif	fy)		Moi	1411	Day Year
P.0	at the ded by the destached	Physician/Med	Part II, Other significant conditions c	antabuting to doubt	but not reculting in the c	ndarh ing onuc	e awan in Part I	23e Did	tobacco use contr	ibute to th	e cause of death?
S,	ires that signed I	by	Hubertension		reroscle		•		/		ably 4 □Unknown
Vital Records,	w require been sign	Completed	31	~			Olomai	Le 24a. Was		Mora auto	any fiadinga ayaylabla
3ec	has has	Idm	cardiovasculo	11 100	iease, M	orbid	ODESI	auto	psy ormed?	rior to cor leath?	psy findings available inpletion of cause of
a		ပို	25. Was case referred to medical				OS Dinas ef	1 ☐ Yes Death   Check only	2 1 No 1	☐ Yes	2 € No
₹	ysicia is cert directo	To Be	examiner?	Hospital: 1 Inpa	atient 2 ER/Outpatie	nt 3 DOA	Othor	ng Home 5 ☐ Resi		er (Specifi	<i>(</i> )
of	g Phy ter this neral c		27. Manner of Death	28a. Date of I		_	Injury at Work?		how injury occurr		,
<u>o</u>	Attending I death. ctor: After y the funer	atlo	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation		Day (ear) Injury	М	1 ☐ Yes 2 ☐ No				
Division	or Attending Physician: tfler death. Director: After this certifici in by the funeral director.	Certification:	3 ☐ Suicide 6 ☐ Could not be 4 ☐ Homicide determined	28e. Place of	Injury - At home, farm, st etc. (Specify)	reet, factory, of	ffice		(Street and Number	er or Rura	l Route Number,
Ö	ital or irs afte ral Dir led in					<del>-</del>					
	To the Hospital or Attention Within 24 hours after deat To the Funaral Director: completely filled in by the	edical	(Check only 2 Medical Exan	niner: On the basis	est of my knowledge, deal s of examination and/or in						
	within 2 To the	Med	29b. Signature and title of certifier	and manner	Stated.	29c. L	icense number		29d. Date signed	i (Month,	Day, Year)
	F3F8		91110	astro		_	9843		July 2		
•	1		30. Name and address of person who	completed cause	of death (Item 23a) (Type					-112	-000
,	4			astro	of death (Item 23a) (Type 900 S. (Sistrar's Signature	aton	AUR B	altimore	e MD	212	29
Sec.		ate	31. Date filed (Month, Day, Year)	32/Reg	istrar's Signature	antis					
18	Regist	rar	JUL 2 5 20	JO JA	ASLI AS POST	The same of the sa					

State of Maryland / Department of Health and Mental Hygiene 2 State Registra Amend #7 Per FH C857 7/25/06 CHItificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3 Time of Death Day 2006 **Physician** MARY MATILDA RUCKER JULY 20  $A^{M}$ 8:15 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 4501 SPRINGDALE AVENUE BALTIMORE CITY N/AIf Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5 Social Security Number 8. Date of Birth (Month, Day, 7: Age (In yrs. last birthday) **Funeral** Days 1 □ M 2 93 Director Usuel Residence of Decedent 10b County 10d. Inside City Limits Town or Location rthen "naturel", or items 23s or 28s-f show the Medical Examiner must be notified at 1Xes 2 □ No 291 TIMO Director 10e.,Street and Number 10f. Zip Code 10g. Citizen o∳What Country? Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 | Yes | 2 | No Race - American Indian Black, White etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No II Yes, specify Quban, Mexican, Puerto Rican, etc.) 14. Race -11. Marital Status filed within 72 hours after □Yes 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No þ ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during file. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other then Elementary/Secondary (0-12) Cotlege (1-4or 5+) me 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle,-Maiden Sumame) Be 1 and 2 should be Health and Mental KNOWN 19a Anformant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or R. al. Foute Number, City or Town, State, Zip Code) Important: If Item 27 is eny injury or other treu 1002190 19500 ale 200. Place of Disposition (Name of cemetery, crematory or other) Method of Disposition Date 20c. Location - City or Town, State permit. Pages 1 Department of H 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility 110 Approximate Interval Between Onset and Death Do not enter the mode of dying, such as cardiac or respiratory arrest 23a. Part1. Enter the disease, or complications that caused the death. shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequ been signed by the attending physicien and should be detached for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months? Month 4☐Pregnant at time of death 5 ☐ Other (specify) No i**gnificant conditions** contributing to death\_but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 Tes 2 X No 24b. Were autopsy lindings available prior to completion of cause of death? 24a. Was an has autopsy performed page certificete 1 Yes 1□ Yes 2 No To the Hospital or Attending Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home ၉ 1 🗌 Inpatient 1 Yes 2 ER/Outpatient 3 DOA 5 Residence 6 ☐ Other (Specify) this the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: After 5 ☐ Pending investigation Natural 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 ☐ Suicide Place of Injury - At home, larm, street, factory, office building, etc. (Specify) 28I. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 \ Homicide hours after within 24 hours a To the Funarel 6 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier cai Medi 29b. Signature and title of certifie 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) State Registrar 2006

			for State Registrar	tate of Maryland		rtment of H tificate of L			ene2006	23300
			1. Decedent's Name (First, Middle, Last)	. \				2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Junior Hic	hardson				July	22, 200	6 12:35 PM
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ŀ	Funeral Director		5. Social Security Number 6. Sex 128 M	7. Age (In yrs. last	Yrs.	Months Days	Hours Min.	(Month, Day, Y	ear) C	ountry)
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	yland		10a. State 10b. County	10c. City, T	own or Lo	cation				10d. Inside City Limits
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	or 28	Olre	10e. Street and Number	`		10f. Zip Code		100	g. Citizen of What C	ountry?
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	er de item	nue		Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ⊠No	13. V	Vas Decedent of Hi Yes, specify Cuba	ispanic Origin? (Si n, Mexican, Puerl	pecify Yes or No- o Rican, etc.)	14. Race - Am Black, Wh	
36	72 hours after death with the Maryland natural', or items 23s or 28e-f show Jical Estainer must be mulified at	by F		If Yes, Give Year or Dates:	1	☐ Yes 28No	Specify:		Specify:	ack
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	g ∪ = 9 a		23a. Part 1. Enter the disease, or complicate	ons that caused the death.	5) Do not ente	51 Balto	Nati P.	Ke Battin	DRE MU	21229 Approximate
	Dhusisian		23a. Part1. Enter the disease, or complicate shock, or heart failure. List only one of Immediate Cause (Final	Va a sai		,	<b>3</b> ,	,		Interval Between Onset and Death
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ord	w require been signature	ted	Dementia					1 Yes	2 NO 3 P	robably 4 Junknown
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<u>io</u>	ath. r: Afte e fun	atio	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year)	Injury		C? Yes 2 □No			
Division of Vital Records,	or Atte	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home building, etc. (Specify)	, farm, stre	eet, factory, office		28f. Location (Stre City or Town,		lural Route Number,
ك	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certific completely filled in by the funeral director.		29a. Certifier 1 Certifying Physici	en: To the best of my knowle	dge, death	occurred at the tim	ne, date and place	, and due to the cau	se(s) and manner a	s stated.
	the Ho in 24 I the Fu npletely	dedical	(Check only 2   Medical Exeminer one)	On the basis of examination and manner stated.	and/or inv	estigation, in my of	pinion, death occu	rred at the time, date	e and place, and du	e to the cause(s)
	To To	Σ	29b. Signature and title of certifier	(*		29c. License	F O	290	1. Date signed (Mon 7-22-0	
•	/		0 000	m.D.		87	570		1-00	<b>V</b>
	ク		30. Name and address of person who comp	leted cause of death (Item 23	100	aryland	Conor	al Haso	ital	
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signature		Jano	gener	w 1100p	1.001	
- 10	Registr		JUL 2 5 2008	Declare D	1	cardi				

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rai', or items Examinar m	d by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 Yes 2 M No If Yes, Give X Year or Dates:		Was Decedent of f Yes, specify Cu I ☐ Yes 2 ☐ N	f Hispanic Origin? ub <i>a</i> n, Mexican, Pu o <i>Specify:</i>	(Specify Yes or N erto Rican, etc.)		Race - Amer Bfack, White ecify:	
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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene State Amend item#8, perFH, 9858, 8/14/06 TT Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Physician 0641 PM ran mill Jun 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6. Sex 1 ★M 2 ☐ F 7. Age (In yrs. last birthday, Social Security Number 9 Birthplace (State or Foreign **Funeral** Days Min. Months Hours 2 Director irainia Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1 1 Yes 2 □ No Director Maryland more 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Apt. 609 Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 M Yes 2 □ No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-II Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: 3 X Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) repairman shoe X 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 7 gera 19a. Informant's Name/Relationship (Type, Print) (brother) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20b. Place of Disposition (Name of Nr. George Lane 20a. Method of Disposition cemetery, crematory 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility (ura of Funeral Service Coensee 21. Signa Home 23a. Parti/Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.

Immediate Cause (Final disease or condition) Approximate Interval Between Onset and Death ensis Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Completed by Physician/Medical Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit that initiated events resulting in death) Last and Due to (or as a consequence of) Division of Vital Records, P.O. Box 68760, IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy õ Month Year Day 5 ☐ Other (specify) 4☐Pregnant at time of death been signed by the should be detached 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Disease 4 Dunknown 1 Yes 2 No 3 Probably Arthu DISCASE 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 autopsy performed? Cardionyonathi this certificate 20 No 1 ☐ Yes 25. Was case referred to media Certification: To Be 26. Place of Death Check only one Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☐ No 12 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be 3 Suicide Place of Injury - At home, farm, street, lactory, office building, etc. (Specily) 28I. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

within 24 hours after death.

To the Funeral Director: After th completely filled in by the funeral To the Hospital

State Registrar

Medical

29a. Certifier

(Check only one)

31. Date filed (Month,

29b. Signature and title of certifier

Day Year

Ò

DHMH 17 Rev 1/2001

**ORIGINAL** 

Union Merrional

and manner stated.

32. Registrar's Signature

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Desair M.D.

Certifying Physician: To the best of my knowledge, depth oppured at the time data and place, and due to the cause(e) and marrier as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s)

29c. License number

29d. Date signed (Month, Day, Year)

July

			For State Registrar	State of Marylan		ent of Health and ate of Death		ene 2006 23303
8	Physicia /Medic		1. Decedent's Name (First, Middle, Last  Devni C 2	House	Shac	1 12 3 5 7 62	2. Date of Death Month	Day Year 2.0 2006 2/29 M
	Examin	<i>*</i>	4a. Facility Name (If not institution, give	Co. General J	tosp. (	ty, Town, or Location of De.	S. 8. Date of Birth	4c. County of Death  Why omky  9. Enthplace (State In Foreign
2 47 × 1 × 1 × 1 × 1	Funeral Director		240 - 44 - 327 - 18 Usual Residence of Decedent	3M 2MF 8	Yrs. Month	s Days Hours Mi	Sept 3	124 north Carolina
	the Maryla 28a-f ehov	Director	10a. State 10b. County  Forsyt	he w	ih Ston -	- Salem Zip Code	100	10d. Inside City Limits  1  Yes 2 No  9. Citizen of What Country?
	death with ms 23a or	Funeral Di	1204 E. 24 11. Marital Status	# St.  12. Was Decedent Ever in U		27/05  edent of Hispanic Origin? Decify Cuban, Mexican, Pue		U. S.A.  14. Race - American Indian,
215-0036	172 hours after death with the Maryland "natural", or Items 23a or 28a-f show refeat Eastheter has be notified at	ρχ	1 ☐ Never Married 2 ☐ Married 3 🖺 Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 1 No If Yes, Give Year or Dates:	1 □ Yes	2 No Specify:		Black, White, etc.  Specify: Black
21215-	within ene. than "	Completed	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12)	cation de completed) College (1-4or 5+)	16a. Decedent's U. (Give kind of life. DO NOT	work done during most of w	orking 16	Cosmetics
Maryland 2	should be filed of Mental Hygin marked other imatic event, II	To Be C	17. Father's Name (First, Middle, Last) Claude	loore		Reth	ame (First, Middle, Ma	kson
-	1 and 2 s Health ar em 27 is ther trau		19a. Informant's Name/Relationship (T Bernette AcC	190 daighter	19b. Mailing Addre	Branish D	VIVE GO	City or Town, State, Zip Code) 2017 9
altimore	t. Pages tment of tent: If It		1  Burial 2  Cremation 3  4  Donation 5  Other (Specify, 21. Signator of Funeral Service Licens	Removal from State	cemetery, crematory of column to the column	m Gardin Ju and Addresonof Farms	1 29 Zear W	linston-Salem, M.C.
Ř	Depariment Department of the Superiment of the S		23a. Part 1. Enter the disease, or comp shock, or heart lailure. List only of	Drufac lications that caused the deat one cause on each line.	th. Do not enter the m	LeCuloh S	T. Balka ac or respiratory arres	Approximate Interval Between
	Physician /Medical Examiner	T.	Immediate Cause (Final disease or condition resulting in death)	a. Arky Due to (or as a conseq	hmic Co	ardine A	rest	Onset and Death
*	* ·	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated eyents	b. Due to (gras a conseq	puence ol):	ne Cardiny.	asule d	Sease
8760,	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as a conseq	quence of):			
P.O. Box 68	death certific e attending pl id for use as t	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ₺ No 9 □ Unknown	23c. If yes, outcome of pregna 1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown	al death 3 □Ectopic			23d. Date of delivery Month Day Year
	The law requires that the site hes been signed by the bage 2 should be detache	þ	Part II. Other significant conditions co	ontributing to death but not res	1	g cause given in Part I.		cco use contribute to the cause of death?  2 No 3 Probably 4 Winknown
		Completed					24a. Was an autopsy performe	
Vita	Physician: Th this certificeteral director, pag	Be	25. Was case referred to medical examiner?	Hospital:		0.4	eath Check only one	
of	ding Phys	tion: To	1/2 Yes 2 No dictined  27. Manner of Death 1/2 Natural 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury at Work?	Home 5 Residen  28d. Describe how	ce 6 □Other (Specify) rinjury occurred
Division	To the Hospital or Attending within 24 hours after death.  To the Funerel Director: Afte completely filled in by the fune	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At h building, etc. (Special			28l. Location (Stre City or Town,	et and Number or Rural Route Number, State)
	To the Hospital within 24 hours a To the Funeral I completely filled	edical (	(Check only 2 Medical Exam	sician: To the hest of my kno iner: On the basis of examina	nwledge death codum	ed at the time, data and pla on, in my opinion, death oc	ne, and due to the cau curred at the time, date	e and place, and due to the cause(s)
	o the	Med	one) 29b. Signature and title of certifier	and manner stated.		9c. License number		d. Date signed (Month, Day, Year)
			Horbut Ka			D0050410	0	7/21/06
	1		30. Name and address of person who	ompleted cause of death (Iter	n 23a) (Type, Print)	D0050 410 Pornee Philip	· Olm	Com
	Sta Registr		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ature	and the second	5	- <u>- u</u>

			1 - For State Registrar	State of Maryla		artment of H			giene Reg. No. 20	06	23304
			1. Decedent's Name (First, Middle, Last,	)				2. Date of De.	ath Day	Year	3. Time of Death
	Physici: /Medic		Leroy	Schaffer		Sr.		July 2	3, <sup>□</sup> 2006		12:30 P M
)	Examin	er	4a. Facility Name (If not institution, give 4095 Rustico Road	street and number)		4b. City, Town, o Middle	River		4c. County Balt	of Death	e
	Funeral Director		5. Social Security Number 215-34-0181  Usual Residence of Decedent	1 M OF F	last birthday) 68 Yrs.	If Under 1 Year Months Days	If Under 24 H Hours M		y, Year)	Cour	place (State or Foreign htry) yland
	the Maryland 28a-f show	Director	10a. State 10b. County  Maryland Baltimor  10e. Street and Number		ity, Town or Lo				10g. Citizen of V		10d. Inside City Limits 1 ☐ Yes 2 No
	h with		4095 Rustico Road			212	20		USA		
980	iges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene.  If Item 27 is marked other than "natural", or items 23a or 28a-f show or other traumatic event, the Medical Examinar motal be modified at or other traumatic event, the Medical Examinar motal be notified at	d by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ever in the Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of H If Yes, specify Cubin 1 ☐ Yes 2X No	tispanic Origin? an, Mexican, Pu Specify:	(Specify Yes or No erto Rican, etc.)	Blac	e - Americ k, White, Whi	
Baltimore, Maryland 21215-0036	within 72 h ane. then "netu	Completed	15. Decedent's Edu (Specify only highest grad	cation le completed) College (1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retired ISTOdian	during most of v	working	16b. Kind of Bu		ŕ
nd 2	tal Hygie d other event, it	Be	12 years  17. Father's Name (First, Middle, Last)		, Cu	iscocian	18. Mother's N	lame (First, Middle,			Y
<u>Ş</u>	nould d Men narke natic	ဥ	John Schaffer  19a. Informant's Name/Relationship (T)	ma Print)	10b Mailie	an Addraga (Stragt		Rural Route Numbe	as City as Town	State 7:-	· Codo)
, Ma	and 2 sleath and 2 sleath and 27 lean		Leroy Schaffer Jr.	son	4095	Rushico 1	Road, M	iddle Riv	er, Mary	land	21220
imore	permit. Pages 1 and 2 Department of Health a Important: if Item 27 is eny injury or other tra		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	Territoval IIOIII State		osition (Name of matory or other place Cemetery	<sub>Сө)</sub> Jı	uly 26, 2006	20c. Location - Dundalk,	•	
Balt	permit. Page Department. Important: It eny Injury o		21. Signature of Funeral Service Licens	Cornel	les ?	onnelly 110 Soll	Funeral ers Poi	Home Of I	Dundalk, Dundalk,	P.A MD.	21222
1	Physician		23a. Part1. Enter the disease, or compl shock, or heart failure. List only o Immediate Cause (Final disease or condition	^ .	ath. (Do not ent Ath	er the mode of dyin	ng, such as card	iac or respiratory ai	rrest,	0	Approximate Interval Between Onset and Death Mo M 4/
	/Medical Examiner		resulting in death)	Due to (or as a conse	quence of):	1					
8760,	cate be executed physicien and the burial-transit	al Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consect.  Due to (or as a consect.)							
P.O. Box 687	The law requires that the death certificate be executed ate has been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of pregr 1 Live birth 2 Fe 4 Pregnant at time of 9 Unknown	al déath 3	Ectopic pregnancy	y		23d. Dat Mo	e of delive	ery Day Year
rds, P	quires that in signed b uld be deta	<u>م</u>	Part II. Other significant conditions co	ntributing to death but not re	sulting in the u	nderlying cause giv	ven in Part I.	23e. Did to			he cause of death? pably 4 □Unknown
	: The law requir cete hes been si page 2 should	Completed						24a. Was autor perio 1 Yes	rmed?   c	Were auto prior to co death?	psy findings available mpletion of cause of
<u> </u>	oertiti rector	Be	25. Was case referred to medical examiner?	Hospital:		3 DOA OU	100	eath (Check only o			
on of	To the Hospital or Attending Physician: The lav within 24 hours eiter death. To the Funerel Director: After this certilicate has completely tilled in by the funeral director, page 2	ıtlon: To	1 Yes 2 No   27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ☐ 28a. Date of Injury (Month, Day Year)	28b. Time o Injury	f 28c. Injui	4   Nursing	Home 5 Resident	dence 6 10th		ý)
Divis	al or Atter efter dea I Director d in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spec	home, farm, sti sify)	reet, factory, office		28f. Location (S City or Tox	Street and Numb vn, State)	er or Rura	I Route Number,
	To the Hospital within 24 hours e to the Funerel Completely tilled	edical C	29a Cartifier 18 Cartifying Phy (Check only one) 2 Medical Exami	aician: To the best of my kn ner: On the basis of examin and manner stated.	nowladge, death nation and/or in	h occurred at the two	ne, date and pla opinion, death oc	ina and dua to the courred at the time,	causa(s) and na date and place,	nner as s and due to	taled. o the cause(s)
	To the within 2 To the complete	₹ Z	29b. Signature and title of certifier			29c. Licens			29d. Date signed	(Month,	Day, Year)
,	2		011.100	ompleted cause of death (Ite	em 23a) (Type,	Print)	117	r Ave	P17	6	1 2 2
	Sta		31. Date filed (Month, Day, Year)	32 Registrar's Sign	nature	7770	IZRIJEN	ir sive	OXX-11 mer	e md	Lilly
	Registr	ar	1111 2 5 200	5 Margares 1	J. Again						

			For State Registrar	State of	Marylan	-	artment of tificate o	Health and f Death		giene Reg. No. 2 (	006	23305
	Physicia	an	1. Decedent's Name (First, Middle, Las	•					2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	Virginia K.  4a. Facility Name (If not institution, give		ith		4b. City Town	, or Location of Dea	Jacy	30,	y of Death	4.550 M
	Examin	er	BALAMORE WASHIN		VE ZV H	(Pais	De Colo	Ca Purk		ANN		PUNIDEL.
	Funeral		Social Security Number 6. S	9X	7. Age (In yrs. I	ast birthday)	If Under 1 Ye		8. Date of Bird	th	9. Birthp	lace (State or Foreign
	Director		210-10-8820	□M 2XF	8	32 Yrs.	Months Day	rs Hours Min	Jan. 02	1 1924	Coun	AL AL
	and w		Usual Residence of Decedent  10a, State 10b, County		10c. City	, Town or Lo	cation				11	0d. Inside City Limits
	the Marylan 28a-f ehow	or	Maryland Anne An	cundal		,, , , , , , , , , , , , , , , , , , , ,		en Burnie				1 ☐ Yes 2 🖔 No
	or 28a.	Director	10e. Street and Number	direct			10f. Zip Code		T	10g. Citizen of	What Coun	try?
	th with		213 Oak Lane N W					21061			USA	
ላ	r dea	Funeral	11. Marital Status	12. Was Deced	dent Ever in U.	S. 13. \	Vas Decedent of Yes, specify C	of Hispanic Origin? (Suban, Mexican, Pue	Specify Yes or No to Rican, etc.)		ce - Americ	
36	urs after death with the Maryla et', or iteme 23a or 28a-f ehov Exarriner in uat be multiled at	by Fu	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes If Yes, Give Year or Da	2 ⊠ No		l□Yes 2⊠N			Spec		ite
1.01	72 hours after death with the Maryland "neturet", or iteme 23a or 28a-f ehow volcal Examiner must be multiled at	ed b	15. Decedent's Ed	lucation	1185.	16a. Deced	lent's Usual Occ	cupation		16b. Kind of I	Business/Inc	lustry
525	- X 30	ple	(Specify only highest gra	de completed) College (1-	-4or 5+)	(Give life. L	OO NOT use ret		orking			
7, 12	ed wil	Completed	12				Sale				ewelry	<u> </u>
$\mathcal{L}_{\mathcal{H},\mathcal{K}_j}$	permit. Pages 1 and 2 shouid be filed withir Department of Health and Mental Hyglene. important: if item 27 ie marked other then eny injury or other traumatic event, the Mones.	To Be	17. Father's Name (First, Middle, Last) Adolphe Kopi					18. Mother's Na Edna	me <i>(First, Middl</i> e, Got1	Maiden Suma CWalles	me)	
为A	12 should h and Mer 7 ie marke Iraumatic		19a. Informant's Name/Relationship (7		\			et and Number or R				Code)
e 2	1 and Healt tem 2		L. Marcia Graf  20a. Method of Disposition	(daughte	20b. P	face of Dispo	sition (Name of	aven Road	Pasader	10 MD 20c. Location		wn, State
25	ages ant of at: if it		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify		state i		natory`or other p 1 Churc	, A. July	/ 22 )06	Pasadei		
	mit. F portar r injur		21. Signature of Funeral Service Licen	-	6		. Name and Add		Stalling			
ä	F F F G		Muschell	Ital	Emos	1	3111 Moi	untain Roa	ad Pasad	iena Mi		
			23a. Part. Enter the disease, or come shock, or heart failure. List only	lications that ca one cause on ea	used the death	. Do not ent	er the mode of o	lying, such as cardia	c or respiratory a	rrest,		Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Col	ion C	ARan	SOMA					Onset and Death
	/Medical Examiner		resolding in dealth)	Due to (d	or as a consequ	uence of):						
		er	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. — Dua to (d	or as a consequ	ierics of):						
	sician and	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events	c.								
o,	ate be executed hysician and the burial-transit	Exa	resulting in death) Last		or as a consequ	uence of):						
8760,	ate Are	dicat		d			1.					
မွ	certific Inding p		IF FEMALE:	23c. If yes, outo	come of pregna	nev -						
Вох	eath certif attanding I for use as	Physician/Me	in the past 12 months?	1 ☐Live bi	nth 2 ☐ Fetal	death 3	Ectopic pregnal Other (specify)				ate of delive onth	ry Day Year
o.	that the d ed by the detached	hysi	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unkno								
e, E	es that igned to be det	by P	Part II. Dther significant conditions of	ontributing to de	ath but not resu	ılting in the ur	nderlying cause	given in Part I.	23e. Did to	obacco use cor	ntribute to th	e cause of death?
g	w require been si should t								101	res 2 □ No	3 Proba	ably 4 🖫 Ónknown
ěč	e law r hes be je 2 sh	Completed							24a. Was autor	SV	prior to con	osy findings available inpletion of cause of
<u>=</u>	ician: The certificate herector, page									rmed?/ 2. No	death?	2□ No
Κ	ysician: is certific director,	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☐ No	Hospital:	patient 2 🗆	ER/Outpatien	t 3 DOA	Othas	ath <i>(Check only o</i> Home 5 ☐ Resid		h /C 4	
o	g Physer this seral di	n: To	27. Manner of Death		f Injury h, Day Year)	28b. Time of Injury	28c. In		28d. Describe			)
jo	utending I death. ctor: After y the funer	atlo	1 Matural 5 ☐ Pending 2 ☐ Accident investigation	1	i, Day (Gai)	пацту		□Yes 2□No				
Division of Vital Records, P.O.	or Attendent efter death	Certification:	3 Suicide 6 Could not be determined	289. Place	of Injury - At ho ig, etc. (Specify	me, farm, str	et, factory, offic	ce	28f. Location (S City or Tox		ber or Rurai	Route Number,
	To the Hospital or Attending Physician: The law requires that the death certific within 24 hours efter death.  To the Funeral Director: After this certificate has been signed by the attanding p completely filled in by the funeral director, page 2 should be detached for use as:	edical C	29a. Certifier 1 Certifying Ph (Check only one)	ysician: To the niner: On the ba and mann	sis of examinat	wledge, death ion and/or inv	occurred at the restigation, in m	time, date and plac y opinion, death occ	e, and due to the urred at the time,	cause(s) and π date and place	anner as sta	ated. the cause(s)
	To th To th comp	Me	29b. Signature and the of certifier	1		10.	29c. Lice	ense number		29d. Date sign	ed (Month, L	Day, Year)
	۲		1 3 M	4		VIII	0	45149		fuly	20 3	2006
	X		30. Name and address of person who	completed cards	of death (Item	23a) (Type,	Print	- Clie	1 Burs	he m	100	1061
	Sta Registr		31. Date filed (Month, Day, Tear) JUL 2-5 200	6 See	egistrar's Signa	ture	de					

Registrar

MD

	4	For State Registrar	State	of Marylar				eaith a Death			Reg. No.	200	5 2	3307
Physicia /Medic			rtt-Mo	llicone						2. Date of De.	21	200	6	6:16 PM
Examin	er	4a. Facility Name (If not institution, give Union Memorial				4b. City		Location of		O	4c.	County of D	eath	
Funeral Director		5. Social Security Number 6. Se		7. Age ( <i>In yr</i> s. 56	last birthday) Yrs.	If Unde Months	r 1 Year	If Under Hours	24 Hrs. 8 Min.	B. Date of Birt (Month, Da	y, Year)	9.	Birthplace Country)	(State or Foreign
nous after begin with the maryand tural; or iteme 23a or 28a-f show al Examiner must be notified at	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland N/A		10c. Ci	ty, Town or Lo		<b>.</b>			-			10d. lr	nside City Limits
3a or 28a It be nati	Funeral Director	10e. Street and Number 2728 Huntingdon A	venue	1		10f. Z	p Code	21211			10g. Citia	zen of What	Country?	
piene. r then "natural" or iteme 23a or 28a-f show the Madical Examiner must be natified at	ρ	11. Marital Status  1 □ Never Married 2 □ Married 3 □ Widowed 4 █ Divorced	12. Was Dec Armed Fo 1 Tes If Yes, Gi Year or D	2 <sup>2</sup> EANo ve		Was Dece If Yes, spo 1  Yes	orfy Cuba	ispanic Ori n, Mexicar Specify:	gin? (Spec n, Puerto R	ofy Yes or No ican, etc.)		I4. Race - A Black, W Specify:	hite, etc.	
r then "natur the Medical	Completed	15. Decedent's Ed (Specify only highest gra- Elementary/Secondary (0-12) 12			life.	kind of w	ork done d ise retired	<i>durina</i> mos	t of working	g	16b. Kir	of Busine		/
arked other	To Be C	17. Father's Name (First, Middle, Last) Robert J. Start	:t							(First, Middle, R. Bea		Sumame)		
27 ie mar r treuma		19a. Informant's Name/Relationship (7) Robert Seabrease	• • • • • • • • • • • • • • • • • • • •	on					er or Rural Aven	Route Number	-	Town, Stat		
Important: If Item 27 Is marked any injury or other treumatic st ance.		20a. Method of Disposition 1 ☐ Burial ②Cremation 3 ☐ 4 ☐ Donation ∫ 5 ☐ Other (Specify		State .	Place of Dispo cemetery, crer etro Ci	sition (Na	me of other plac	(a)	7/25/	ite	20c. Lo	cation - City	or Town, S	
any inj once.		21. Signature of Fineral Service Licen	See He	nss	/ Bi	Name a urgee 631 E	nd Addres -Hen 'alls	ss of Facilit SS-Se Road	itz F I, Bal	uneral timore	Ноп	e, In	g. 21	211
sician ledical		23a. Part i. Enter the disease, or companies took, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	aB	caused the dea each line. RALN (or as a consec	th. Do not ent		de of dyin						App	roximate rval Between et and Death & HOURS
physician and the burial-transit	al Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to	(or as a consec	quence of :	ART	EP.	Y D	ISE	ASE			20	OYEARS
ittending or use as	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 M No 9 ☐ Unknown	1 Live	itcome of pregn birth 2 ☐ Fet nant at time of o	aideath 3□	∃Ectopic (	pregnancy				2	3d. Date of Month	delivery Day	Year
n signed by the a uld be detached f	Ď	Part II. Other significant conditions or	ontributing to c	death but not res	sulting in the u	nderlying	cause giv	en in Part I		1	obacco u Yes 2[		e to the cau	use of death?
nis certificate has been si I director, page 2 should I	Completed									1 ☐ Yes	osy rmed? 2 No	24b. Were prior death	1?	ndings available ion of cause of No
Dera	tion; To Be	25. Was case referred to medical examiner?  1  Yes 2 No  27. Manper of Death  1 Natural 5 Pending 2  Accident investigation	28a. Date (Mor		ER/Outpatier 28b. Time o Injury		28c. Injun Worl	er: 4□Nu	ursing Hom	Check only one 5 Residence Rescribe	dence 6		Specify)	
i Director: A	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Plac	e of Injury - At h ling, etc. (Spec	nome, farm, str ify)	reet, facto				Bf. Location (. City or Tox	Street and wn, State,	d Number or )	Rural Rou	ite Number,
To the Funeral completely filled	Medical C	29a. Certifier (Check only one) 1  Certifying Ph 2  Medical Exam	tiner: On the l	a best of my kn basis of examin oner stated.	owledge deat ation and/or in	h couma vestigatio	at the tim	na data an pinion, dea	ad plane, ar	nd fue to the d at the time,	cause(s) date and	and manner place, and	us stated due to the	cause(s)
Toti	M	29b. Signature and title of certifier	Tomi	c, H.I	),	1	T2		946		-	signed (M		
Sta Registr		30. Name and address of person who are all and address of person who are all and are all and are are all and are are all and are are all and are are are are are are are are are are	TOHU 32.	se of death (Ite	ature			IEM	ORI	AL H	OS	PITA	L ,	LD.

06-05330 Lennard Solomon

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

mara Obibinib		1-For State Of Maryland / Department of health and Certificate of Death	ia Meritai riygi		. No. 900	5 5000
Physicia dical Exami	an/	1. Decedent's Name (First, Middle,Last)  LEONARD JAMES SOLOMON	!	Date of Death Month	Day Year	3. Time of Death U
ulcai Exaiiii	Hei		or Location of Death	uly 22, 20	4c. County of Death	
		Sinai Hospital Baltimore	,		N/A	
Funeral Director		5. Social Security Number 250-86-1425 6. Sex 17. Age (In yrs. last birthday) Funder 1 Yes Months Da	un Hours Min	06/26	(MM/DD/YYYY) 9. Bir Foreig / 1951 Co	thplace (State or gn SC untry)
nd show any <u>ce.</u>		Usual Residence of Decedent  10a. State				10d. Inside City Limits 1 X Yes 2 No
ith the Maryland  23a or 28a-f show	Director	10e. Street and Number 10f. Zip Code 2131 TWINBRIDGE DRIVE 29	9505	100	Citizen of What Coul	ntry?
ath with the interest in the rest.	Funeral	11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of House Marital Armed Forces?  14. Marital Status	dispanic Origin? (Specifian, Mexican, Puerto Rica			ican Indian, Black,
hours after de 'uatural", or Examin r mu	ē	1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year US AIR 1 Yes 2 X No 15. Decedent's Education (Specify only highest grade compates)  16. Decedent's Education (Specify only highest grade compates)		done	Specify BI	ACK
	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)  1 2 TH  College (1-4 or 5+)  AIRMAN	fe. DO NOT use retired)	done	US AIRF	
MD 21215-0036 and 2 should be filed within 72 lealth and Mental Hygiene. ten 27 is marked other than ' traumatic event, the Medical		17. Father's Name (First, Middle, Last)  JAMES SOLOMON	18.Mother's Name (Fir		,	
2121 ould be fil Mental I marked	o Be	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Str.	EUGENIA eet and Number or Rura			e, Zip Code)
<b>∑</b> 2 5 5 5 5 5			BRIDGE RD			
Baltimore, permit. Pages I and Department of Heal Important: If iten injury or other tra		20a. Method of Disposition  1	CEM 7/28	8/06	20c. Location - City or FLORENCE	
Balt permit. Depart Import injury		21. Signature of Funeral Service Licensee 22. Name and Addre	ss of Facility HOWI BERTY HEIO	ELL FU	JNERAL HO	ME 21207
Physician /Medical		23a Pari 4. Enter the disease, or complications that caused to death. Do not enter the mode of dyin failure. List only one cause on each line.	g, such as cardiac or res	spiratory arres	st, shock, or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause (Final disease or condition resulting in death)  a AtherDsclerDtic Cardiovascular Disease Due to (or as a consequence of):				Death
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):				
od Sit	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last    C. Due to (or as a consequence of):				
o, e be executed ysician and burial - transit		d. UNPENDED AMENDED				
760, freate be g physici the buri	/Medical	IF FEMALE: 23c. If yes, outcome of pregnancy 23b. Was decedent pregnant in the			23d. Date of delivery	
Box 687  e death certific  the attending  ed for use as t	rsician	past 12 months?  1 Ves 2 No 9 Unknown  1 Live birth  2 Fetal death  4 Pregnant at time of death  5 Other (Specify)  9 Unknown	Ectopic pregnancy		Month [	Day Year
P.O. B es that the de igned by the e detached f	by Phy	Part II. Other significant conditions contributing to death but not resulting in the underlying cause	given in Part I.		acco use contribute to	
rds, P.O  requires that s been signed b				1 Yes	2 No 3 Prob	oably 4 V Unknown  Itopsy findings available
of Vital Records,  ng Physician: The law requir  After this certificate has been si  nneral director, page 2 should b	Completed			autops perforn 1 Yes 2	y prior to death?	completion of cause of
tal Rectian: The certificate ector, page	Φ		ce of Death (Check only		V No 1 Ye	es 2 No
F Vit	To B	examiner? 1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ✓ ER/Outpatient 3 DOA	Other Nursing H		esidence 6 Dthe	r:
ion of tending Pheath.		(Month, Day, Year)	jury at Work? 286 Yes 2 No	d. Describe ho	ow injury occurred	
ivis lor At after d Direct	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, street, factory, office (Specify)	building, etc. 28f	f. Location (St or Town, Sta		iral Route Number, City
To the Hospital within 24 hours To the Funeral completely fille	Medical C	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opini and manner stated.				
F 3 F 8	Me	29b. Signature and title of certifier 29c. Lice	nse number		29d Date signed (Mo	nth, Day, Year)
2		30. Name and address of person who completed cause of death (Item 23a)  Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn Street, Ba	ultimpre. MD 21201	1		
	tate	31. Date filed (Month, Day, Year) 32 Registrar's Signature			<del></del>	
Regis	trar	JUL 2 5 2006 Been D. Sparker				

			For State Registrar	State of Mary		partmen <i>ertificat</i>			nd Me		jiene	06	23309
	Physici	an «	Decedent's Name (First, Middle, Las JoAnn	M .	Szel:	ioa			2.	Date of Dea Month	th Day	Year	3. Time of Death
	/Medio Examir	_	4a. Facility Name (If not institution, give	street and number)	Q			Location of I			4c. Coun	ty of Death	
1.0	Funeral Director		5. Social Security Number 217-40-2803 1  Usual Residence of Decedent	V .	n yrs. last birthda 51 Yrs.	Months	1 Year Days	If Under 24 Hours	Hrs. 8. Min.	Date of Birth (Month, Day Dec 2 7	,1944	9. Birthp Cour Mary	place (State or Foreign ntry) y Land
	filed within 72 hours after death with the Maryland Hygiene. wher than "neturel", or Iteme 23e or 28e-f show with the Medical Exeminer must be notified at	Director	10a. State 10b. County	imore	Notti		Code 212	36			I0g. Citizen o	f What Cour	10d. Inside City Limits 1 ☐ Yes 2X No ntry?
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: if Item 27 is marked other than "neturel; or Iteme 23e or 28e-f show any Injury or other treumatic event, the Madical Examinat must be notified at once.	d by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Eve Armed Forces? 1 Yes 2 No If Yes, Give Year or Dates:	r in U.S. 1	3. Was Deced If Yes, spec	dent of Hi cify Cuba		n? (Specif Puerto Ric	y Yes or No- can, etc.)	14. Ra BI	ace - Amendack, White,	etc.
Maryland 21215-0036	d within 72 h giene. rr then "netu Ine Madical	Be Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0-12) 12th	ducation de completed) College (1-4or 5+)	(G.	cedent's Usua ive kind of wo a. DO NOT u inistr	ork done d se retired	during most o ()			16b. Kind of	Business/In uranc	,
yland	ould be file I Mental Hyg wrked othe	To Be C		misano				Regi	ina	Cars			
Baltimore, Mar	ages 1 and 2 sh int of Health and t: If Item 27 Is n y or other treum		Daniel Szelig  20a. Method of Disposition  1 월 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specific	a (husband	1) 940 20b. Place of Dis	)1 Dav	VNV a	le Ro	oad I	Notti	r, <i>City or Town</i> ngham 20c. Location Baltir	Md City or To	21236 own, State
Baltir	permit. P Departme Importan any Injur		21. Signature of Fineral Service Lice	·		22. Name ar	nd Addres	ss of Facility	Caczo	orows		neral	Home, P.A
	Pnysician /Medical Examiner	ner n	23a. Part1. Enter the disease, conshock, or heart failure. Ist only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, and an analysis of the Cause. Enter Underlying Cause (Disease or injury)	b. Due to (or as a co	SCPS;		de of dyin	g, such as ca	ardiac or ri	espiratory arr	est,		Approximate Interval Between Onset and Death
8760,	physicien and the burial-transit	dical Examiner	Cause (Disease or injury that initiated events resulting in death) Last	cDue to (or as a co	onsequence of):								
.O. Box 6	The law requires that the death certific ite has been signed by the attending p tage 2 should be detached for use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	23c. If yes, outcome of p 1 Live birth 2 L 4 Pregnant at tim 9 Unknown	Fetal death	3 ⊟Ectopic pi 5 ⊟ Other (sc					1	ate of delive	ery Day Year
ords, P.	w requires that been signed b should be det	by	Part II. Other significant conditions of	ontributing to death but n	ot resulting in the	e underlying o	cause give	en in Part I.	_		bacco use co es 2 □ No		ne cause of death?
Vital Records,	CO SAL	Completed							_	24a. Was a autops perfor 1 ☐ Yes	sy med?		psy findings available mpletion of cause of
Vit	Physicien: r this certific ral director,	o Be	25. Was case referred to medical examiner?  1 Yes 2 No	Hospital:	2 ER/Outpa	tient 3 DC	Oth	05	•	5 Resid	ne) ence 6 🗆 O	ther (Specif	(v)
ion of	Jing Afte tune	atlon: T	27. Manner of Death 1  Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Ye	ear) 28b. Time Injur	e of 2	28c. Injun Worl		280		ow injury occu		
Division	or At ifter c Direct in by	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury building, etc. (5	- At home, farm, Specify)	street, factor	y, office		281	Location (S City or Town		nber or Rura	al Route Number,
	To the Hospital within 24 hours a To the Funerel completely filled	edical		niner: On the basis of example and manner stated	amination and/or								
<b>\</b>	To th Within To th	Me	29b. Signature and title of certifier	Alay. MI	`	29		S coo		2	9d. Date sign	and (Month,	
7	10		30. Name and address of person who	completed cause of death	h (Item 23a) (Typ				1	D - 1 - 1			
	St: Regist		Gelareh Alavi, 31. Date filed (Month, Day, Year) JUL 25 2006	32. Registrar's		kave	n Bo	outeva	ard	ратсі	more,	. DIYI	Z1Z3 <del>Y</del>

		,	For State Registrar	State of Ma	-	epartment of Certificate of	Health and If Death	Mental Hy	giene	6	23310
	Physici /Medi		1. Decedent's Name (First, Middle, Last) Esther Hunter Si	nger				2. Date of De Month	Day	Yeer 06	3. Time of Death 4:15 PM
	Examir		4a. Facility Name (If not institution, give Carroll Hospital  5. Social Security Number 6. Sex	Center	e (In yrs. last birthd	West	n, or Location of Dea Minster ar   If Under 24 Ho		4c. County of	roll	(0)
	Funeral Director			M 2 F	93 Yrs. Months Days Hours Mir				Y99913	Count Count	ace (State or Foreign
	e Maryland la-f show	ctor	10a. State 10b. County Maryland Carroll		10c. City, Town o	rLocation linster				10	0d. Inside City Limits 1 ☐ Yes 2 ☐ No
	ath with th	rai Director	10e. Street and Number 205 St. Mark Way A	pt. 122		10f. Zip Cod	21158		10g. Citizen of Wh		try?
036	be filed within 72 hours after death with the Maryland tal Hygiene. Id other than "natural", or Items 23a or 28a-f show other than "natural", or Items 23a or 28a-f show event, the Medical Eventinal pust be rotified at	by Funerai	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Armed Forces? 1 ☐ Yes 2 ☐ If Yes, Give Year or Dates:		13. Was Decedent of If Yes, specify C	of Hispanic Origin? ( uban, Mexican, Pue No Specify:	Specify Yes or No rto Rican, etc.)	o- 14. Race Black, Specify:	White, e	
Maryland 21215-0036	e filed within 72 ho al Hygiene. I other than "natu vent, the Medicel	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0-12)	cation e completed) College (1-4or 5	(G	ecedent's Usual Oci live kind of work do e. DO NOT use rel Bookkeepe	ne during most of wo ired)	orking	16b. Kind of Busin		
yland 2		To Be C	17. Father's Name (First, Middle, Last) Francis L. Hunte:	?				me (First, Middle	a, Maiden Surname, auntt	)	
e, Man	and 2 shi ealth and m 27 Is m		19a. Informant's Name/Relationship (Ty Barbara Davison - o		532	3 Tower 1	et and Number or F	sboro, N	C 27410		
Baltimore,	permit. Pages 1 ar Department of Hea Important: If item any injury or othe		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ R  4 ☐ Donation 5 ☐ Other (Specify)		cemetery,		ardens Ju			sbur	g, Md.
Bal	permi Depar Impor any ir		21. Signature of Funeral Service Licenson  23a. Part1. Enter the disease, or compli		I the death Death		funeral ( sterstown				d. 21117
8760,	Medical Examiner  the purel-transit sthe burnal-transit	dicai Examiner	tmmediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Einer underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as	cular	accia	lent		I	Onset and Death	
.O. Box 68	The law requires that the death certificate be executed the has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	3c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 Fetal death	3 Ectopic pregna 5 Other (specify)	ncy		23d. Date Month		y Day Year
<u>α</u>	w requires that is been signed by should be detailed	by	Part II. Other significant conditions cor	tributing to death b	/	e underlying cause	given in Part I.	23e. Did t	tobacco use contrib Yes 2 No 3		a cause of death?
Il Records,		Completed						24a. Was auto perfo 1 ☐ Yes	psy pric prmed? dea	or to com ath?	sy findings available pletion of cause of
ion of Vital	Attending Physician: Th r death. ector: After this certificate by the funeral director, pag	tion: To Be	25. Was case referred to medical examiner?  1  Yes  2 No  27. Manner of Death  Natural  5  Pending  Accident investigation	ospital: 1 XInpatie 28a. Date of Inju (Month, Da	y 28b. Time	e of 28c. in	Other: 4 Nursing		one) dence 6 ⊡0ther how iniॄury occurred		
Division	al or Atter s after dea al Director ed in by the	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injuding, etc	ury - At home, farm, c. (Specify)	street, factory, office	0	28f. Location ( City or To	Street and Number wn, State)	or Rural	Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After completely filled in by the funer	edical	29a. Certifier (Check only one) 1 Certifying Physical Exemination (Check only one)	icien: To the best ner: On the basis of and manner sta	examination and/o	eath occurred at the r investigation, in m	time, date and plac y opinion, death occ	e, and due to the urred at the time,	cause(s) and mann date and place, and	er as sta d due to t	ted. the cause(s)
)	With Com	Σ	29b. Signature and title of certifier  A, J, Helo	и, м. Д.	•		01769		July 2		2006
	1			LOU, M. ]	). CA	De, Print)	OSPITAL C	ENTER,	WESTMINS	TER,	MD 21157
	Sta Regist	_	31. Date filed (Month, Day, Year)  JUL 2 5 20	100	ar's Signature	Spart o					

6-05092			Please Type or	Print in E	lack Indelible Ink			
aniel Wimple Tay		l State	of Maryland / Depa	rtment of tificate of		Hygiene	2.0	106 2321
Physician/		ecedent's Name (First, Middle,La		incate or		2. Date of Death	No. C. U	3. Time of Death
Medical Examine	/	aniel Winf	1 00 1 10 1		b. City, Town, or Location of De	July 16, 20	Day Year 06 4c. County of I	0458 hrs
		Baltimore Washington Me			Glen Burnie		Anne Arur	
Funeral Director	55	000019	M 2 F	ast birthday) Yrs	If Under 1 Year   If Under 24 Months   Days   Hours   I	Hrs. 8 Date of Birth		9. Birthplace (State or Foreign Country)
Maryland 28a-f show any 1.at once.	10a.			Town or Location	Oak			10d. Inside City Limits 1 Yes 2 No
vith the Maryland \$23a or 28a-f show notified at once.	3	Street and Nymber	a have Ap	+.>	21207		Citizen of What	4
s after death with ral", or items 23, niner must be no hy Furneral		Marital Status  Never Married 2 Marrie  Widowed 4 Divorce	12. Was Decedent Ever in U. Armed Forces? Yes 2 No If Yes, Give Year or Dates:	If Ye	Decedent of Hispanic Origin? s, specify Cuban, Mexican, Pue		14 Race - A White, e	American Indian, Black, etc.
36 in 72 hour han "natu lical Exan	15.	Decedent's Education (Specify of lementary/Secondary (0-12)	only highest grade completed)  College (1-4 or 5+)		s Usual Occupation (Give kind st of working life. DO NOT use	retired)	16b. Kind of Busir	ess/Industry
should be filed with and Mercal Hygiene and Mental Hygiene 7 is marked other in natic event, the Mercal To Be Comm		Father's Name (First, Middle, Las	laylor Jr		Shi	me (First, Middle, Ma	homps	
ore, MD 2121 stand 2 should be fi of Heath and Mental If item 27 is marked ther traumatic event.	Ju	Informant's Name/Relationship (	or/Nite	19b. Mailing 6	1uttering Le	or Rural Route Numb	denton	state, Zip Code)
Page Page nent annt:	20a. 1 4	Method of Disposition  Burial 2 Cremation 3  Donation 5 Other Specific	Removal from State	Place of Disposit crematory or other	on (Name of cemeter), or place?)  The place of cemetery is a second control of the place of the	121/06	Wood la	two, mb
	V	Signature of Funeral Service Light Part I. Binter the disease, or com	nsee	87	La Liberty 16.	Randall	stown, 1	Approximate Interval
Physician /Medical xaminer	lmm	failure. List only one cause on e			- Hode of dying, oder do odrate		st, shock, of fleat	Between Onset and Death
	- 1	uentially list conditions, by, leading to immediate se. Enter Underlying Cause	Due to (or as a consequence o	f):				-
red Insit	(Dis	ease or injury that initiated nts resulting in death) Last	Due to (or as a consequence o	F):	, <u>.</u>			
6 be execut	2	UNPENDED	AMENDED					
cox 6876 eath certificat eath certificat eath certificat eath certificat for use as the	IF F 23b.	EMALE: Was decedent pregnant in the past 12 months?  Yes 2 No 9 Unknow	23c. If yes, outcome of preg  1 Live birth 4 Pregnant at time of de	2 Feta	Il death 3 Ectopic pre	gnancy	23d. Date of de Month	olivery Day Year
P.O. E res that the c signed by the be detached	3	II. Other significant conditions		esulting in the un	derlying cause given in Part I.	l		rite to the cause of death?  Probably 4 Unknown
Division of Vital Records, P.O. B rat or attending Physician: The law requires that the drafter death.  al Director: After this certificate has been signed by the led in by the funeral director, page 2 should be detached by the funeral director, page 2 should be detached by the physician. To Re Completed by Divisional deather the physician of t	Ourplete					24a. Was ar autopsy perform 1 • Yes 2	prio	re autopsy findings available or to completion of cause of ath?  Yes 2 No
cian: certific		Was case referred to medical examiner?	Hacrital		26.Place of Death (Che			
of Viting Physic	2 27	1 Yes 2 No Manner of Death	Hospital: 1 Inpatient 2 28a. Date of Injury	ER/Outpatient 28b. Time of In			esidence 6 (	Other:
Division of Vital Recipion of Vital Recipion of Hospital or Attending Physician: The Inthia 24 hours after death of the Functal Director. After this certificate I completely filled in by the funeral director, page	1 2	Natural 5 Pending  Accident Investiga	FOUND: tion Jul 16, 2006	FOUND: 0417 hrs	1 Yes 2 ✔ No	Driver of auto	ejected from	vehicle
Division o the Hospital or Attent ithin 24 hours after death ithin 24 hours after death on of the Funeral Director: ompletely filled in by the	3 4	Suicide 6 Could no determine	t be	ome, farm, street	, factory, office building, etc.	28f. Location (Stror Town, Sta PRoute 100, C	ite)	or Rural Route Number, City
To the Hos within 24 hos ompletely		on only	cian: To the best of my knowled er:On the basis of examination a and manner stated					

30. Name and address of person who completed cause of death (Item 23a) Patricia Aronica-Pollak MD. State 31. Date filed (Month, Day, Year) Registrar

Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201

29c. License number

O.C.M.E.

29d. Date signed (Month, Day, Year)

July 16, 2006

## Please Type or Print in Black Indelible Ink

James Vigue	State of Maryland / Department of Health and Mental Hygiel  1- Foi State Registrar  Certificate of Death	Reg. No.
Physician/ Medical Examiner	1. Decedent's Name (First, Middle, Last)  James M. Vique 2. Dat  Mo	te of Death Jay Year 0850 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4232 Nicholas Avenue  Baltimore	4c. County of Death A
Funeral Director	136-40-2928 1X M 2 F 56 Yrs. Months Days Hours Min. Fe	ate of Birth(MM/DD/YYYY) 9 Birthplace (State or Poreign New Jers
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Usual Residence of Decedent  10a. State Maryland  10b. County Maryland  10c. City, Town or Location Baltimore City  10e. Street and Number 5620 Belair Road  11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin? (Specify Y	
2 hours after "natural".	Armed Forces?    Armed Forces?	Specify: White
21215-00 unld be filed with Mental Hygien marked other cevent, the M. For the	17 Father's Name (First, Middle, Last) Joseph Vigue 18. Mother's Name (First, Margaret)	Middle, Maiden Surname) Unk no√vn
MD 21 d 2 should tht and Me n 27 is ma ummatic ev	19a. Informant's Name/Relationship (Type, Print )  Miss Amanda Vigue - Daughter  19b. Mailing Address (Street and Number or Rural Rd. 3819 E. Joppa Rd. Apt.	Γ-2 Baltimore, MD 21236
Baltimore, MD 21215-0036 permit Pages I and 2 should be filed within 7 Department of Health and Mental Hygiene Important: If item 27 is marked other than injury or other traumatic event, the Medica To Be Comple	20a Method of Disposition  1 Burial 2 X Cremation 3 Removal from State  4 Donation 5 Other Specify  20b. Place of Disposition (Name of cemetery)  27/28/0	6 Towson, MD
Balt permit Departr Import injury	21. Signature of Funeral Service Licensee 22. Name and Address of Facility Paltin Leonard J. Ruck, Inc.	. 5305 Harford Rd.
Physician /Medical Examiner	23a. Part I. Enter the disease, or complications har caused the death. Do not enter the mode of dying, such as cardiac or respin failure. List only one cause on each line  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause  23a. Part I. Enter the disease, or complications har caused the death. Do not enter the mode of dying, such as cardiac or respin failure. Discovering the mode of dying, such as cardiac or respin failure. Discovering the mode of dying, such as cardiac or respin failure. Discovering the mode of dying, such as cardiac or respin failure. Discovering the mode of dying, such as cardiac or respin failure. Discovering the mode of dying, such as cardiac or respin failure. Discovering the mode of dying, such as cardiac or respin failure. Discovering the mode of dying failure failure. Discovering the mode of dying failure fail	atory arrest, shock, or heart Approximate Interval Between Onset and Death
ecuted and transit al Examiner	events resulting in death). Last  Due to (or as a consequence of):  d.	
Division of Vital Records, P.O. Box 68760, To the Uspital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit ledical Certification: To Be Completed by Physician/Medical Exhibitation: To Be Completed by Physician/Medical Exhibitation:	X UNPENDED  AMENDED  item#23a,27,28a~f,perME,g857,7/28/06 TT  IF FEMALE: 23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  AMENDED  item#23a,27,28a~f,perME,g857,7/28/06 TT  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (Specify) 9 Unknown	23d. Date of delivery  Month Day Year
, P.O. E res that the signed by the be detached d by Ph		le. Did tobacco use contribute to the cause of death?  Yes 2 No 3 Probably 4 Unknown
Records, The law requires ficate has been signage 2 should be Completed	1	a Was an autopsy performed?  Yes 2 No 1 24b. Were autopsy findings available prior to completion of cause of death?  Yes 2 No 1 Yes 2 No
Division of Vital Records, P.O. sprial or Attending Physician: The law requires that the ours after death meral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detack Certification: To Be Completed by P	1 Natural 5 Pending Fnd 7/17/2006 Fnd 8:30 am 1 Yes 2 X No unk	Residence 6 Other Scene escribe how injury occurred
Divi. Hospital or / 24 hours after Funeral Dire tely filled in b	3 Suicide 6 X Could not be determined (Specify) Found at home 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Log Balft  29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to	cation (Street and Number or Rural Route Number, City Town, State) 232 Nicholas Avenue Limore, 1232 Nicholas Avenue
To the Hos within 24 hd To the Fun completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the tin and manner stated  29b Signature and title of certifier  29c. License number	
	O.C.M.E.  30. Name and address of person who completed cause of death (Item 23a)	July 18, 2006
B	Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD  31 Date filed (Month, Day Year) 32. Registrar's Signature	21201
State Registrar	JUL 25 2006 Regular & Systems	
OCME 2006	ORIGINAL	

Teresa Lee Van-Aulen

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		- For State Registrar				Certific		Deat	th			F	leg. No	21	JUI	6 2331
Physicia	n/	Decedent's Name (First	me (First, Middle,Last) Teresa Jo Van Aulen						2	Date of Dea Month	ath Day	Year		3. Time of Death		
ledical Examir		Teresa Jo		<u> </u>		a J. Va			T			July 21, 2	2006		. Daath	1839 hrs
		4a. Facility Name (if not in University Hospi		ve street and nu	umber)		4		Town, or Lo		f Death			c. County o Harford	Death	
Funeral Director		5. Social Security Numbe 242-06-2324		M 2 <b>X</b> F	7. Age (In	yrs. last bi	rthday) Yrs.	If Und Month	ler 1 Year ns Days	If Under Hours	Min.	8 Date of B 08/01	•		Foreign	nplace (State or n intry) NC
	H	Usual Residence of Dece	·				110.	<u> </u>		<u> </u>		00/01	/13	J+		NO NO
any			County		100	. City, Town	n or Location	on							- 1	10d. Inside City Limits
faryland 28a-f show	اۃ	PA La	ncast	er	_   N	liller	svill	e								1 X Yes 2 No
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f sho matic event, the Medical Examiner must be notified at once	Director	10e Street and Number						10f. Zip					_	tizen of Wh	at Coun	try?
th the		21 Hillcres	st Dri				Lacina	175			-0/0		U.S			an Indian Dinak
ath wi	Funeral	11. Marital Status  1 Never Married 2	2 X Marrie		orces?				ent of Hispa ify Cuban, f			cify Yes or N can, etc.)	D-	White		can Indian, Black,
fter de		3 Widowed 4	Divorce	d If Yes, Give Ye or Dates:	2 <b>X</b>	No	1	Yes 2	X No	specify:				Specify:	Whi	ite
ours a	ğ p	15. Decedent's Education		only highest gra		ted) 16a	. Decedent		Occupation				16b	Kind of Bus	iness/Ir	ndustry
36 in 72 h	ompleted	Elementary/Secondary	y (0-12)	College (	1-4 or 5+)		lomema		J			,	١	wn Ho	me	
21215-0036 uld be filed within 72 Mental Hygiene marked other than c event, the Medical	ĕ	17. Father's Name (First,	, Middle, Las	t)			ioineine	IKCI	18	B.Mother'	s Name (F	irst, Middle,			ilic	
215 ee filec ital Hy ked ol	Be C	James Bill							Т	helm	a Be	asley				
Baltimore, MD 21215-00: pennit Pages I and 2 should be filed with Department of Health and Mental Hygiene Important: If item 27 is marked other tinjury or other transmatic event, the Med		19a. Informant's Name/R				11	_					ral Route Nu				
Baltimore, MD pernit Pages I and 2 she Department of Health and Important: If iten 27 is injury or other tranman		Larry Van A		Husbar	<u>nd</u>	20b. Place	21 Hi	illc	rest	Driv	<u>e, M</u>	<u>illers</u> Date	vil	le, P	A 17	7551
of Her tr		1 Burial 2 X Ci		Removal f	rom State	crema	atory or oth	er place	<del>)</del> )							
LimC Page tment	Ļ	4 Donation 5				Hillt	op Sv	/C.	Corp.	of Facility	7/24	/2006		owson	, Ma	aryland •
Balti permit Departir Imports injury o		21 Signature of Funeral		Bates			530	)5 H	arfor	d Ro	ad.	Baltin	ı. K iore	MD	2101	14
Physician		23a. Part I. Enter the disc	ease, or con	plications that	caused the	death. Do										Approximate Interval Between Onset and
/Wedical Examiner		failure. List only on Immediate Cause (Final		ach line. Multiple In	juries											Death
ZXaIIIIIei		or condition resulting in	death)	Due to (or as	a consequ	ence of):										
> _	je l	Sequentially list condition if any, leading to immediate	iate	Due to (or as	a consequ	ence of):										
	Examiner	cause. Enter Underlying (Discussion injury that it events resulting in death	itiated	Due to (or as	a consequ	ence of):							_			
outed nd Iransit		events resulting in death		d												
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8760, tificate be ng physic as the bur	/Me	IF FEMALE: 23b Was decedent pregr		23c. If yes	outcome o	of pregnanc	y 2 Fe				pregnano	cv	23	3d. Date of Month		ay Year
Box 68 e death certifi the attending ed for use as	Ciar	past 12 months?	F-2	4 Preg		e of death		ner (Sp			, pregnan	,				
that the death cered by the attendidetached for use	Physicia	1 Yes 2 No 9	-	9 01111						n.	4.1	22 n.d	1-1			the source of death?
F. P.O. ires that the signed by		Part II. Other significan	nt condition:	s contributing	to death bu	ut not result	ing in the u	inderlyin	ig cause giv	ven in Pa	ırı. I.					the cause of death? ably 4 Unknown
ords, F w requires to been sign should be	ted	1										24a Was				topsy findings available
COTC law re has be	Completed by			-								auto	ormed?	ď	eath?	ompletion of cause of
al Recian: The certificate		25 Was case referred to	n medical	Γ			-		26.Place	of Death	(Check or	1 Yes	2	No 1	<b>✓</b> Ye	s 2 No
/ital	o Be	examiner?	No	Hospital: 1	Inpatient	2 🗸 ER/	Outpatient	3 🗌		Other4		Home 5	Resid	tence 6	Other	
of Vital I fing Physician: After this certifi funeral director,	-1	27. Manner of Death	110	28a. Dat (Mon	e of Injury th, Day,Year; wn	281	. Time of I	njury	28c. Injury		. IP	8d. Describe				
ision Attendii r death ector: / by the fu	atio	1 Natural 5 2 Accident	Pending Investiga	ation			ıknown			es 2 🗸	No					
Division of Vital Records, pital or Attending Physician: The law requirous after death eral Director: After this certificate has been stilled in by the funeral director, page 2 should the cert of th	ertification:	3 Suicide 6	Could no	ot be		/ - At home,	farm, stree	et, factor	ry, office bu	iilding, et	- 1	or Town,	State)			t Route Number, City
non fill	O	4 Homicide 29a Certifier 1 Card		ician: To the b	() Local		leath occur	red at th	ne time dat	e and pla						t, Port Deposit, M
To the Ho within 24 l To the Fur completely	Medical	(Check only one) 2 Med	lical Examir	er:On the basis	s of examin	ation and/o	r investigat	tion, in n	ny opinion,	death oc	curred at	the time, dat	e and p	lace, and d	ue to the	e cause(s)
F & S	Me	29b. Signature and title	of certifier	and manner	310100			25	9c. License	number			29d	. Date signe	ed (Mor	nth, Day, Year)
		Calas	lle	23/1	<,				O.C.N	1.E.			Ju	ly 22, 20	06	
y		30. Name and address of					111 Pen	n Stra	ot Ralti	more *	MD 212	01				
	tota	Zabiullah Ali, M		sistant Med	Registrar's		i i ren	iii Stie	et, Daitil	more, l	VID 414	-				
S Regis	tate trar	and thomas, or	-y1 - 54/	oeno	-	1		M	,							
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DHMH 17 Rev 1/2001 OCME 2006

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene [] [] State Registramend #20b Per FH G857 7/25/06 emificate of Death 3. Time of Death P 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month 8:15 **Physician** Son Ker 200 /Medical 4c. County of De 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner If Under 24 Hrs. 8 9. Birthplace (State or Foreign 6. Sex yrs. last birthday, Social Security Number **Funeral** Months 1 M 2 X F 244-28-6988 Usual Residence of Decedent 3 North Carolina Director 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 1 Yes 2 No Completed by Funeral Director Maryland MORE 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Race - American Indian, Black, White, etc. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status ☐Yes 2 No Yes, Give 1 Never Married 2 ☐ Married 1 ☐ Yes 2 🕱 No Specify: If Yes, Give Year or Dates: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life, DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 1an 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) To Be en 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) which ter, ST. 4622 20b. Place of Disposition (Name of cemetery, crematory or other p 20c. Location - City or Town, State 20a. Method of Disposition 7/26/06 1 Burial 2 Cremation 3 □Removal from State Green Mount Crematory permit. Page Department of Important: If any injury or once. 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address I Fairly
Joseph, Ly Ky 21. Signatus Funegai Home W. North Ave. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Due to (or as a consequence of): resulting in death) angetire Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as consequence of): Examine Gypertensia that initiated events resulting in death) Last Due to (or as a consequence of) by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 □ Yes 2 □ No 24a. Was an autopsy performed? 1 ☐ Yəs 2 3 No 25. Was case referred to medical examiner? 26. Place of Death | Check only one Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 □ Yes 2 ⊡-1√0 3 DOA 1 Inpatient 2 ER/Outpatient 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Certification; 1 Watural 5 Pending investigation 2 Accident 6 Could not be determined 3 Suicide

**Physician** /Medical Examiner burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Division of Vital Records, P.O. Box 68760, this ieral Director: After th filled in by the funeral death. within 24 hours after d

To the Funeral Direct
completely filled in by

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Heatth and Mental Hygiene. Int: If Item 27 Is marked other than "natural", or Items 23a or 28a-f show

Baltimore, Maryland 21215-0036

other traumatic event. I'm Medical Exeminer must be notified at

ö

 Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 29a. Certifier 1 Dertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 3146 0 CUNU MD 171

31. Date filed (North, Dag, Year 2006

N. ENTAW IT Ante 308 BALTIMORE MI) A. HAIHMAMD, 821 32: Registrar's Signature Courses

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

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State of Maryland /	Department of Health and Mental Hygiene

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Dawayne Watson,		State of Maryland / Department of H  For State  Certificate of D			200	6 2331
Physician	R	edistrar  Decedent's Name (First, Middle, Last)	2. 1	Reg. N Date of Death	No.	3. Time of Death
Medical Examine	r	Dawayne Watson, Jr.		Month Da July 19, 2006	y Year 4c. County of Death	2109 hrs
	4	and a series ( a series )	Baltimore		V/	4
Funeral Director			f Under 1 Year If Under 24Hrs. 8 Months Days Hours Min.	Date of Birth (N	Foreign	hplace (State or number)
Director	e	U5-75-9647 1⊠M 2□F Yrs.	31111	Aprill	1,2006	1 V .
any		Oa. State 10b. County 10c. City, Town or Location				10d Inside City Limits
-f show once.	<u> </u>	Oe. Street and Number	MORE Of, Zip Code	1100	Citizen of What Coun	1 Yes 2 No
death with the Maryland or items 23a or 28a-f show any must be notified at once.	<u>.</u>	4009 White Ave Apt.	2/20/0	l log.	1151	Ä
r death with t or items 23s must be not		Armed Forces? If Yes,	ecedent of Hispanic Origin? (Specif specify Cuban, Mexican, Puerto Ric		14. Race - Americ White, etc.	an Indian, Black,
ter deat ", or ite	- 1	1 Yes 2 X No	es 2 👿 No specify:		Specify: R/	ack
2 hours afte "natural", 1 Examiner		15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's	Usual Occupation (Give kind of work of working life. DO NOT use retired)		b Kind of Business/Ir	ndustry
han 7	naialdillon	Elementary/Secondary (0-12)  College (1/4 or 5+)	N/A		N/A	
e, MD 21215-003  I and 2 should be filed with Health and Mental Hygiene item 27 is marked other it reaumatic even, the Mer	υl	17. Father's Name (First, Middle, Last)	18 Mother's Name (Fi	irst, Middle, Maid	den Surname)	th
2121: ould be fill I Mental E s marked ic event,	0	19a Informant's Nam Relationship (Type, Print ) MD 2 1 19b. Mailing Ad	ddress (Street an Number or Rura	al Route Number	, City or Town, State,	Zip Code)
e, MD 2 and 2 shou Health and N item 27 is n		VIS. Latasha Smith 14009  20a. Method of Disposition 20b. Place of Dispositio	WhiTe Ave	, 3A E	Oc. Location - City or	Na. 2/2016 Town, State
W	١	1 X Burial 2 Cremation 3 Removal from State crematory or other		1/2001	lanch	uno Md
Baltimor permit. Pages Department of Important: If injury or othe	r	4 Donation 5 Other Specify: 21. Significant of Funeral Service Licensee	ne and Addless of Facility	Fines	- I Home	DA.
	-	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the	mode of dying, such as cardiac or re	ve. B	shock, or heart	Approximate Interval
Physician /Medical		takine. List only one cause on each line.  Immediate Cause (Final disease a Sudden infant death syndro				Between Onset and Death
xaminer	1	or condition resulting in death)  Due to (or as a consequence of):				
	<u>آ</u> و	Sequentially list conditions, if any, leading to immediate course. Enter Underlying Course  Due to (or as a consequence of):				
	Examine	C. Due to (or as a consequence of):				
cecuted n and rransit	<u> </u>	d d				
O, e be ex ysiciar burial	ledical	IF FEMALE:  AMENDED  item#23a.27.perME.	<u>8859,9/21/06 TT</u>		23d. Date of delivery	
Sox 68760, death certificate be re attending physici of for use as the burit	an/	23b. Was decedent pregnant in the past 12 months?	death 3 Ectopic pregnance	y	Month E	Day Year
Box 6876: death certificate the attending phyed for use as the	Physician/N	1 Yes 2 No 9 Unknown 9 Unknown	r (Specify)			
oby the	by P	Part II. Other significant conditions contributing to death but not resulting in the unc	derlying cause given in Part I.		cco use contribute to	the cause of death?
day F				24a. Was an	24b Were au	topsy findings available
COFC law re e has be	Completed			autopsy performe		completion of cause of
I Re n: The rtifficat or, pag	ပ္ပို	25 Was case referred to medical	26 Place of Death (Check onl			2 110
Vita hysicia this ce	0	examiner?  1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient			sidence 6 🗸 Other	: Scene
	on:	27. Manner of Death  1 X Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b Time of Injury (Month, Day, Year)	28c. Injury at Work? 28  1 Yes 2 No	3d. Describe hov	v injury occurred	
Divisior  Hospital or Attend 24 hours after death Funeral Director: stely filled in by the	Certification:	2 Accident Investigation 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street,	factory, office building, etc. 28	8f Location (Stre		ıral Route Number, City
E 3 5 E	Certi	4 Homicide determined (Specify)				
To the Hos within 24 h To the Fun completely	Medical	29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	d at the time, date and place, and dun, in my opinion, death occurred at the	ue to the cause(s he time, date an	s) and manner as star d place, and due to th	ted. ie cause(s)
E 2 E 8	Me	29b. Signature and title of certifier	29c. License number O.C.M.E.		29d Date signed (Mo July 20, 2006	nth, Day, Year)
		30. Name and address of person who completed cause of death (Item 23a)	J.J.IVI.E.			
		Ana Rubio MD. Assistant Medical Examiner 111 Penn Str	reet, Baltimore, MD 21201			
Sta Regist		31. Date filed (Month, Day, Year) 32. Jegistrar's Signature	ke .			
	_					

06-04955 Marvin White Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene 1- For State Certificate of Death Reg. No Registrar edent's Name (First, Middle,Last) 2. Date of Death Physician/ Month Day July 11, 2006 **Medical Examiner** 1941 hrs 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Dea Maryland General Hospital Baltimore 5. Social Security Number 6 Sex Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State of **Funeral** Months Days Hours Foreign Director Country) 1 X M 2 Yrs Usual Residence of Decedent 10b. County any 10c, City, Town or Location 10d, Inside City Limits 28a-f show 1 XYes 2 No with the Maryland **Funeral Director** 10e. Street and Number 10g Citizen of What Count 10f. Zip Code 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Marital Status Was Decedent Ever Race - American Indian, Black, hours after death 1 X Never Married Armed Forces? White, etc. Married 2 X No Yes o. Divorced If Yes, Give Year 1 Yes 2 No specify Specify. "natural" ⋧ 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) College (1-4 or 5+) 72 permit Pages I and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "injury or other traumatic event, the Medical. Baltimore, MD 21215-0036 Father's Name (First, Middle, Last) æ 19b. Mailing Address (Street and Number or ral Route Number 20b. Place of Disposition (Name of cemetery crematory or other place) Cremation 3 Donation 5 Other Specify gnature of Funeral Service Licens, e Name and Jose. ath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Physician Approximate Interval failure. List only one cause on each line. Between Onset and /Medical Death Heroin and Methadone intoxication and cocaine use nediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of) cause. Enter Underlying Cause (Disease or injury that initiated Due to (or as a consequence of). events resulting in death) Last Hospital or Attending Physician: The law requires that the death certificate be executed 24 hours after death. and Physician/Medical X UNPENDED attending physician or use as the burial AMENDED item#23a,27,28a-f,perME,g857,7/28/06 TT Division of Vital Records, P.O. Box 68760, 23c. If yes, outcome of pregnancy 23d. Date of delivery 3b. Was decedent pregnant in the Live birth Day Fetal death Year past 12 months? 2 Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 Yes 2 No 3 Probably 4 V Unknown Completed 24a. Was an 24b. Were autopsy findings available autopsy prior to completion of cause of After this certificate has performed? death? Yes 2 No 1 🗸 Yes 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> DOA Inpatient 2 V ER/Outpatient 3 Nursing Home 5 1 🗸 Yes 2 No 28a. Date of Injury (Month, Day, Year) 28b. Time of Injury 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Natural within 24 hours after death.

To the Funeral Director: 5 Pending Yes 2 No Fnd 7/11/2006 unk in by the ımk Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc 28f. Location (Street and Number or Rural Route Number, City 6 X Could not be Suicide or Town, State)523 Sanford Place determined (Specify) House Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29b. Signature and title of certifie 29c. License number 29d Date signed (Month, Day, Year) O.C.M.E. July 12, 2006 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Ana Rubio MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) State Registrar

DHMH 17 Rev 1/2001 OCME 2006

Baltimore

Maryland

USA

14. Race - American Indian, Black, White, etc.

Specify:

White

9. Birthplace (State or Foreign

10d. Inside City Limits

Approximate Interval Between Onset and Death

Year

1 Yes No

29d. Date signed (Month, Day, Year) TIMONIUM, MD 21093

23d. Date of delivery

1 Yes

Day

3 ☐ Probably 4 XUnknown

24b. Were autopsy lindings available prior to completion of cause of death?

2□ No

Month

State Registrar

31. Date liled (Month; Day,

State of Maryland / Department of Health and Mental Hygiene 2 0 0 6 Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Year Month 1444M Physician 23 WITHERSPOON JULY 2006 EONARD /Medical 4b. City, Town, or Location of Death 4c. County of Death 4a. Facility Name (If not institution, give street and number) Examiner 7. Age (In yrs. last birthday) Baltimore 413 Hopkins Johns If Under 1 Year If Under 24 Hrs. | Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** 21458-9568 1 M 2□F North (arolina Director Usual Residence of Decedent e filed within 72 hours after death with the Maryland if Hygiene. other than "naturel", or flems 23s or 28s-f show 10d. Inside City Limits 10b. County 10c. City, Town or Location 10a. State Pages 1 and 2 should be filed within 72 hours after death with the Maryla nent of Health and Mental Hyghens and ment of Health and Mental Hyghens "atture!", or ttems 23s or 28s-f show and if it is marked other than "nature!", or thems 23s or 28s-f show any or other treumstic event, I a Medical Exam set must be notified at ury or other treumstic event, I a Medical Exam set must be notified at 14 Yes 2 □ No ma Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 2 Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Was Decedent Ever in U.S. Armed Forces? 11. Marital Status Black White etc. 1 ☐ Yes 2 ☒ No ff Yes, Give Year or Dates: Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: Slack Š 3 Widowed 4 Divorced Be Completed 16a. Decedent's Usuaf Occupation (Give kind of work done during most of working life. DO NOT use retired), 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade comp completed) Colfege (1-4or 5+) Elementary/Secondary (0-12) relde 12 H IA 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) arolyn 1 ce ames 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1508 N. Decker me Balto, md, 21213 mother andyn Powell-20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State -24-06 metro permit. Page Department of important: if eny injury or 4 □ Donation 5 □ Other (Specify) 21. Signature of 5 heral Service Kice nee 270 Fred HILTON Pass of marcy June done Batto, modelly Approximate fnterval Between Onset and Death 23a. Partil Errey the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or lear failure. List only one cause on each line. Immediate use (Final disease or condition resulting in death) Pnysician LIVER FAILURE /Medical Due to (or as a consequence of): **Examiner** GASTRO-ESOPHAGEAL Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner physician and s the burial-transit Due to (or as a consequence of): P.O. Box 68760 Physician/Medical use as IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 🗷 No ğ 4☐Pregnant at time of death 5 ☐ Other (specify) 9☐ Unknown 9 🖂 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records. ٥ 1 ☐ Yes 2 ☐ No 3 ☑ Probably 4 ☐ Unknown icate has been sig . page 2 should b FAILURE KIDNEY Completed 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☑ No 24a. Was an BRAIN INJURY HYOXIC autopsy performed? this certificate has 1□ Yes 2 X No Hospital or Attending Physicien: 26. Place of Death (Check only one) 25. Was case referred to medical examiner? funeral director. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☑ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 🔀 No 28a. Date of fnjury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death Certification: After 5 Pending investigation 1 X Natural 1 Yes 2 No within 24 hours after death. 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 🗌 Suicide filled in by 4 🗌 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier npletely i 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier SJAIN, MD JULY 23, 2006 RES-000 BALTIMORE 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) JOHNS HOPKINS HOSPITAL, 600 NORTH WOLFE STREET, MARYLAND 21287 THE SHAMIK JAIN, MD 3 Flegistrar's Signature 31. Date filed (Month, Day, Year) State JUL 2 5 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene-  $\cup$   $\cup$   $\cup$ 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Vear **Physician** 1500 M JAMES ICESON WHITE, SR. 2006 22 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner 0+ Bult-more N/AHospital Baltimore Sinai If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Date of Birth (Month, Day, Year) 11/03/1955 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign 5. Social Security Number **Funeral** Country) MARYLAND 1**☆**M 2□F 50 Director 218-64-1471 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d Inside City Limits 10a State 10b County or Iteme 23a or 28a-1 ehow other traumatic event, the Medical Examiner must be notified at N/A BALTIMORE CITY Yes 2 No MD Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21206 4901 TRUESDALE AVENUE USA 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married 1 ☐ Yes 2 X No Specify: Specify: BLACK Š 3 Widowed 4 Divorced Year or Dates: "natural', 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry 12 should be filed within 7 hand Mental Hygiene. 7 is marked othar than "r Elementary/Secondary (0-12) College (1-4or 5+) WELDER LONG FENCE CO. 10 18. Mother's Name (First, Middle, Maiden Sumame)
GENEVA FRIENDLY 17. Father's Name (First, Middle, Last)
EDDIE WHITE, SR. Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: if item 27 is m any Injury or othar traum <u>once.</u> 4901 TRUESDALE AVE, BALTIMORE, MD 21206 VANESSA L. WHITE WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial ② Commation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) 7/28/06 METRO CREMATORY CATONSVILLE, MD 22. Name and Address of Facility HOWELL FUNERAL HOME 21206 21. Signature of Funeral Service Licensee 4600 LIBERTY HEIGHTS AV, BALTIMORE, MD Enter the disease, or complications that caused by death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heartfailure. List only one cause on each line. Approximate Interval Between Onset and Death Immediale Cause (Final Priysician Due to ( r as a consequence of): 1 day disease ocondition resulting in death) /Medical **Examiner** fa.lux Heart 3 years Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner certificate be executed the burial-transit Due to (or as a consequence of): the attending physician hed for use as the burial Division of Vital Records, P.O. Box 68760 Physician/Medical IF FFMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Day in the past 12 months? 1 ☐ Yes 2 ☐ No 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an Artery Disease loronary autopsy performed 2 No 1 ☐ Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 this 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? Certification: Hospital or Attanding 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No s after death. 2 Accident 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) determined 4 Homicide 24 hours a 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical To the Hos within 24 hd To the Fun completely i 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 22,2006 19475 Tremed Ulid 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Verd Sinai Franco Hosp.ta 31. Date filed (Month, Day, Year) 32 Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

JUL 2 5 2006

James

Baltimore, Maryland 21215-0036

ORIGINAL

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible.
AMEND THE PROPERTY OF THE PROPERTY 1 - For State Registrar Certificate of Death Reg. No.-1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month Year Physician. 24 2006 KONNGLI /Medical 4a. Facility Name (If not institution, give street and number 4b. City, Town, or Location of Death 4c. County of Death Examiner BAKTIMORE JOHNS HOPKINS

5. Social Security Number LANK BAYNEW MEDICAL CENTER BALTIMORE
If Under 1 Year | If Under der 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1⊠M 2□F 321-76-0507 36 Director 06/17/1970 IL Usual Residence of Decedent deeth with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Depertment of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or itema 23s or 28a-f show any Injury or other traumatic avant, the Medical Examinating the notified at once. 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits Baltimore 1 X Yes 2 □ No Director N/A MD 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Parington St. Apt.

12. Was Decedent Ever in U.S. Armed Forces?

1 □ Yes 2 ☑ No

1 Yes, Give

Year or Dates: Ap+. Паа 21223 us А Completed by Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 ☐ Yes 2 No Specify: 3 Widowed 4 Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) G. E. D. College (1-4or 5+) Food Service Worker NIA Food 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Samuel Skyles ဂ Gladys West 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Samuel Skyles (father) 5911 Central Ave Baltimore MD 21207 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Park 7/31/2006 Randalstown, MD 22. Name and Address of Facility were SVC Vaughn C Greene Funeral SVC 6151 Balto North P. Ke, Baltimore, MD 21229 21. Signature of Funeral Service Licensee Vauchn Greene 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to (or as a consequence of): Examiner MITRAL VALVE ENOCAPDITIS and Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Due to (or as a consequence of) deeth certificate be executed ed by the ettending physicien and detached for use as the burial-transit HNE INFECTION Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Day Year 5 Other (specify) 9 Unknown 9 Unknown been signed by should be detacl Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Local Sta 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 @Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate hes t irector, page 2 s Sec performed? 1 Yes 2 No 1 ☐ Yes 2 No or Attanding Physician: director, 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) ၉ Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1'a Inpatient 2 ER/Outpatient 3 DOA this neral Diractor: After the filled in by the funeral 27 Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Matural death. м 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 🗌 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or At within 24 hours after d To the Funeral Direct completely filled in by 4 - Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Mgnth, Day, Year) RES-ODE Donnele 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) AVENUE -EASTERN 31. Date filed (Month, Day, Year) JUL 25 2006 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Billion

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day 5024 19 Alice M. White 2006 /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner John Hopkins Bayview Baltimore n/a If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months | Days | Hours | Min. | (Month, Day, Year) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthdey) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 K F 60 Director 218-44-4366 12-14-1945 Maryland Usual Residence of Decedent 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD n/a Baltimore 1 Yes 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or items 23a or USA 6218 Shipview Way 21224 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🔀 No White Specify Specify: 3 ☐ Widowed 4 ☐ Divorced "natural". Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 18b. Kind of Business/Industry Cross-Blackwell marked other than Elementary/Secondary (0-12) College (1-4or 5+) permit. Pages 1 and 2 should be filed w Department of Health and Mental Hygies Important: If Item 27 Is marked other it any injury or other traumatic event, IIIa 2002. assembly 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Doris Collison Richard A. Dovel 19a. Informant's Name/Relationship (Type, Print) Husband 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6218 Shipview Way, Baltimore, MD 21224 Roland M. White Jr. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 7/24/2006 Baltimore, MD Oaklawn \*4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Joseph N. Zannino Jr. FH 21. Signature of Funeral Service Licensee 23a. Part1. Enter the disease, or complications that caused the deeth. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 263 S. Conkling St. Baltimore, MD 21224 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Ovarian year /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, if any, learning to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a consequence util Examine attending physicien and for use as the burial-transit Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical as the IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetel death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ð 1 ☐ Yes 2 ☑ No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ♣ No 24a. Was an autopsy performed? 1 Yes 26 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 X Yes 2 □ No 2€ER/Outpatient 3☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. injury at Work? 27. Manner of Death 28d. Describe how injury occurred After t Certification; To the Hospital or Attending 1 Natural 5 Pending investigation To the magnetic within 24 hours after death.

To the Funeral Director: After the formal on by the formal standing the forest standing the formal standing the formal standing the formal s death. 1 ☐ Yes 2 ☐ No 2 Accident 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. icai 29a Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4940 JHBV 31. Date filed (Month Day, Yar) 32 Registrar's Signature State Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 8:15 ам Nelson Joseph Wisner /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 5408 Hoffmanville Rd. Manchester Carroll | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | Aug | 1. | Month | Days | Year | Aug | 1. | Month | Days | Year | Aug | 1. | Month | Days | Year | Aug | 1. | Month | Days | Year | Aug | 1. | Month | Days | Year | Month | Days | Year | Month | Days | Year | Month | Days | Year | Month | Days | Year | Month | Days | Year | Month | Days | Year | Month | Days | Year | Month | Days | Year | Month | Days | Year | Month | Days | Year | Month | Days | Year | Month | Month | Days | Year | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | Month | 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign Country) Mary Land **Funeral** 213-40-0667 1 M 2 □ F 65 Director Usual Residence of Decedent 2 should be filed within 72 hours after death with the Maryland and Mental Hygiene.

Is marked other than "natural", or items 23a or 28a-f ehow 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 27 is marked other than "natural", or items 23a or 28a-f ehow traumatic event, the Medical Exercities must be notified at Carroll 1 ☐ Yes 2 ☐ No Maryland Manchester Funeral Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5408 Hoffmanville Rd. 21102 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 🕅 No If Yes, Give Baltimore, Maryland 21215-0036 1 ☐ Yes 2 Ĭ No Specify: Specify: White ð If Yes, Give Year or Dates: 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Selfemployed Truck Co. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Basil Wisner Gladys Haines ဂ္ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is m any injury or othar traum <u>once.</u> Shelby Wisner - wife 5408 Hoffmanville Rd. Manchester, Md. 21102 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State New Lutheran Cem. July 25,2006 <sup>¹</sup> 4 □ Donation 5 □ Other (Specify) Manchester. Md. 22. Name at Address of Facility Charles .A. Charliss Dr. Hanchester, 21. Signature of Funeral Service Licensee Latel 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Adenocarcinomu Colon **Physician** Metagtatic two years /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, it any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed and Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 igned by the attending physician be detached for use as the buria Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy 2 Fetal death in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4□Pregnant at time of death 5 Other (specify) 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ - S' o 3 ☐ Probably 4 ☐ Unknown 1 Tes page 2 should Completed peen 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an this certificate has autopsy performed? Yes 20 No 1 ☐ Yes Physician: Be 25. Was case referred to medical 26. Place of Death (Check only or examiner? Other: 4 Nursing Home 5 Schesidence 6 Other (Specify)

Injury at 28d. Describe how injury occurred Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Certification; To 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? After 1 Natural 2 Accident 5 Pending 1 □ Yes 2 □ No investigation within 24 hours after death To the Funeral Director: the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide 🌠 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical (Check only one) 2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Murth Charles St. Bultimore; Maryland 21209 6569 evine 32. Signature 31. Date filed (Month, State Registrar

DHMH 17 Rev 1/2001

ORIGINAL

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P.O. Box 68760,	
of Vital Records, F	i i

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		_ FOI	State of Maryland / D			ntal Hygien	enns	23323
		State Registrar		Certificate of E		Rag. N	ē. U U U	
Physicia /Medic		1. Decedent's Name (First, Middle, Last)	athaniel	Ward,	00 -		ay 2006	3. Time of Death
Examin		4a. Facility Name (If not institution, give st 500d Samaritar	reet and number) HOSPITAL	4b. City, Town, or Baltir		4	c. County of Death	1
Funeral Director		5. Social Security Number 6. Sex	7. Age (In yrs, last birti	hday) If Under 1 Year Months Days	If Under 24 Hrs. 8. Hours Min.	Date of Birth (Month, Day, Yea 1-22, 19	36 9. Birth	nplace (State or Foreign untry)
and ow		Usuat Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location				10d. Inside City Limits
Mary P-f eho	tor	MD	Bai	1 timore				1 Yes 2 No
alter deeth with the Maryland or tems 23e or 28e-f ehow on net must be notified at	Director	10e. Street and Number		10f. Zip Code	201	10g. C	itizen of What Cor	uptry?
deeth v	Funeral		2. Was Decedent Ever in U.S.		DOG spanic Origin? (Specify	Yes or No-	14. Race - Amer	rican Indian.
after or fte	by Fun	1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give ( Year or Dates:	13. Was Decedent of His If Yes, specify Cubar	Specify:	an, etc.)	Black, White	
72 hours 'naturel', dical Exa	ted	15. Decedent's Educi (Specify only highest grade	ation 16a.	Decedent's Usual Occupa (Give kind of work done di		16b.	Kind of Business/l	ndustry
within and the series of the s	Completed	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	1 lealer 's	-	Donl	1 1
filed v Hygie other t	e Co	17. Father's Name (First, Middle, Last)	24ears	arifu	18. Mother's Name (Fi	rst, Middle, Maide	in Sumame)	stry
2 should be filed wi and Mental Hygien is marked other th sumatic event. Its	To Be	Samuel	ward		Cilaa	lus v	vard	
s 1 and 2 should be filed within 72 hr thealth and Mental Hygiene. Item 27 is marked other than "natu other traumatic event, tra Medical		19a. Informant's Name/Relationship (Typ	11.1.	Mailing Address (Street a				ip Code)
Health tem 27		20a. Method of Disposition	The Daughter 18	Disposition (Name of	Cr. Wind		Location - City or 1	91044 Town, State
permit. Pages 1 an Department of Heal Important: if Item 2 eny injury or other once.		1 ☐ Surial 2 ☐ Cremation 3 ☐ Re 4 ☐ Donation 5 ☐ Other (Specify)	moval from State  Wood	crematory or other place	7/25/	ou Ba	Himore	e.MD
permit. Departn Imports eny inju		21. Signature of Funeral Service Licenses		22. Name and Address	s of Facility / Val	-ynn C.	Grueni	Juneres Sur
40.5 a		23a. Part1. Enter the disease, or complic	ations that caused the death. Do o		Mande	alstan,	mD 21	11 33 Approximate
Dhuaisian		shock, or heart failure. List only one	cause on each line.		4	spiratory arrest,		Interval Between Onset and Death
Physician /Medical		disease or condition resulting in death)	Due to (or as a consequence of	pneum	onia			
Examiner		Sequentially list conditions, b.						
Day A de	Examiner	Sequentially list conditions, if any, leading to inmediate cause. Enter Underlying Cause (Disease or injury	Dila to (or as a consequence o	4)				
be executed cian and curial-transit	Exar	that initiated events c. resulting in death) Last	Due to (or as a consequence of	rf):				
	Ilcai	d.						
The law requires that the death certificate be to has been signed by the attending physic bage 2 should be detached for use as the but	Physician/Medica	IF FEMALE: 23	c. If yes, outcome of pregnancy				22d Date of deli	
death e atter	iciar	23b. Was decedent pregnant in the past 12 months?	1☐Live birth 2☐Fetal death 4☐Pregnant at time of death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)			23d. Date of deli	Day Year
that the dead by the detached	Phys	9 Unknown	9□Unknown					
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w requir been si should	ietec		active fulmo	proint Di	sease	24a. Was an		topsy findings available
The larate has	Completed	0,1110	ich vo rolling	mary Di	3 Edge	autopsy performed? 1 Yes 2 □ N	prior to c death?	ompletion of cause of
icien: certifica	BeC	25. Was case referred to medical examiner?	110000- 10000-		26. Place of Death (C.	heck only one)		
ding Physicien:  After this certific funeral director,	٠ <u>۲</u>	1 Yes 2 No	ospital: 1 ☑Inpatient 2 ☐ ER/Out 28a. Date of Injury 28b. T	patient 3 DOA Othe	4 Nursing Home	5 Residence		cify)
nding F ath. r: After e funer	ation	1 Natural 5 Pending 2 Accident Investigation		ijury Work	? ′es 2 □No	2000.00	21, 0000110 <b>0</b>	
To the Hospital or Attending Physicien: within 24 hours after death of the Funeral Director: After this certifical completely filled in by the funeral director,	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, far building, etc. (Specify)	rm, street, factory, office	28f.	Location (Street a City or Town, Sta	and Number or Ru te)	ral Route Number,
spitel nours a neral [		29a. Certifier 1 Certifying Physi	cian: To the best of my knowledge	, death occurred at the time	e, date and place, and	due to the cause(	s) and manner as	stated.
the Ho in 24 } the Fu	edicai	(Check only 2 Medical Examination)	er: On the basis of examination and and manner stated.	Vor investigation, in my op	inion, death occurred a	it the time, date a	nd place, and due	to the cause(s)
Vith Vith	Σ	29b. Signature and title of certifier	e MBChB	29c. License	number 000	Jul	ate signed (Month	n. Day, Year) 2006
X		30. Name and address of person who cor					ALT IMOR	RE MD -
Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's Signature	-UCH NHVU	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,D 3r		21239
Registi		JUL 2 5 2006	and the same of th	Should)				
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			OR	IGINAL				

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	1- For State Certificate of Death	0000 0000
Physician/	1. Decedent's Name (First, Middle,Last)	Reg. No.  2. Date of Death  Month  3. Time of Death
Medical Examiner	Jeffrey David Wilson	July 17, 2006 Year 0728 hrs
	4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Deatl 313 Timber Grove Road Owings Mills	4c. County of Death Baltimore County
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr.	s. 8. Date of 8irth(MM/DD/YYYY) 9. 8irthplace (State or
Director	915.74.4007   1XM 2 F   40 Yrs.   Months   Days   Hours   Mir	2.21.1966 Foreign Country) MD
any	Usual Residence of Decedent  10a State	10d Inside City Limits
ž		1 Yes 2 YNo
the Maryland a or 28a-f sh tiffed at once	MD Baltimore Owings Mills  10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
uin the Maryland 23a or 28a-f show notified at once.	313 Timber Grove Rd 21117	U.S.A
> £3  \\ \	11. Mantal Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (S	
ter death ", or iter er must	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 No specify:	Specify: Black
2 hours afte "natural", IExaminer	15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use ret	work done 16b. Kind of Business/Industry
36 n 72 h nan "n ical E	Elementary/Secondary (0-12) College (1-4 or 5+)	
5-0036 led within 72 hour Hygiene to other than "natu the Medical Exan Completed	17. Father's Name (First, Middle, Last) 18. Mother's Name	United Electric  e (First, Middle, Maiden Surname)
21215 21215 Muld be filee Marked o marked o c event, th	William David Wilson Mclvi	na Sounders
D 21 should and Me 7 is man natic ev	19a Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or	Rural Route Number, City or Town, State, Zip Code)
, MC and 2 s ealth a em 27	Melvina Wilson / mother 313 Timber Grave (Ca) 20a. Method of Disposition (Name of cemetery.	Date 20c. Location - City or Town State
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", injury or other traumatic event, the <u>Medical Examiner</u> To Be Completed by I	1 Naurial 2 Cremation 3 Removal from State crematory or other place) 4 Donation 5 Other Specify  Wood lawn Cemetery 7	24 ole Baltimon MD
Baltimo permit. Pag Department Important: injury er et	21. Signature of Funeral Service Licensee  22. Name and Address of Facility  8728 Liberty Rd	TION IDALITIME C. MID
Dep Dep inji	Van h. C. Ci	anda115+own, MD 21133
Physician /Medical	23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	8etween Onset and
Examiner	Immediate Cause (Final disease or condition resulting in death)  A Hypertensive atherosclerotic cardiovascular of Due to (or as a consequence of)	lisease Death
	Sequentially list conditions, b	
nsit Examiner	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause Consequence of Discourse in the Michael Consequence of Discourse in the Mi	
ed ssit	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):	
and and	x unpended = amended item#23a,PII,27,perME,g857,7/27/06 TI	1
O 0 20 0	IF FEMALE: 23c. If yes, outcome of pregnancy	23d. Date of delivery
ox 6876 ath certificate attending phy or use as the sician/M	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnant at time of death 5 Other (Specify)	ancy Month Day Year
of Vital Records, P.O. Box 6876( ing Physician: The law requires that the death certificate After this certificate has been signed by the attending phy funeral director, page 2 should be detached for use as the on: To Be Completed by Physician/IMe	1 Yes 2 No 9 Unknown 9 Unknown 9 Unknown	
P.O. s that the gned by e detach	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  Diabetes Mellitus	23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 Unknown
ds, F quires en sign uld be	Diabetes Perritus	24a. Was an 24b. Were autopsy findings available
Records, The law requires froate has been significate has been significate Completed		autopsy prior to completion of cause of death?
Division of Vital Records, tal or Attending Physician: The law requints after death all Director: After this certificate has been sled in by the funeral director, page 2 should the triffication: To Be Completed	25. Was case referred to medical 26. Place of Death (Check	1 Yes 2 No 1 Yes 2 No only one)
Vita vysicia vysicia this cel	examiner?	ng Home 5 Residence 6 ✔ Other: Scene
n of V ling Ph After t funeral	27. Manner of Death  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury 28c. Injury at Work?	28d. Describe how injury occurred
Sior Attenor r death ector: by the	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
Division o Hospital or Attending 24 hours after death Funeral Director: Aft tely filled in by the fune	3 Suicide 6 Could not be determined (Specify)	or Town, State)
Division of Vital I To the Hospital or Attending Physician: within 24 hours after death To the Fineral Director: After this certificompletely filled in by the funeral director. ledical Certification: To Be (	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and	
To the Hos within 24 h To the Fun completely	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated.	
	29b. Signature and title of certifier  29c. License number  O.C.M.E.	29d Date signed (Month, Day, Year)  July 18, 2006
	30. Name and address of person who completed cause of death (Item 23a)	
7	Pamela Southall, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201
State Registrar	31. Date filed (Month, Day, Year)  32. Registrar's Signature	
DHMH 17 Rev 1/2001	ORIGINAL	3

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	Amende	d	1- State Registrar 8 per fh, g		Ce	rtificate of	Death	0 Date -(D	Reg. No.		
	Physici	an	1. Decedent's Name (First, Middle, Las	Alica	117			2. Date of D Month	Day	Yeer	3. Time of Death
, j	Medic		4a. Facility Name (If not institution, give	a atract and number)	00	4h City Town o	or Location of Death			06 ounty of Deat	12:50P M
	Examin	er	HOLY CROSS HOS			Silver				tgome	
_	Funeval	- 3	5. Social Security Number 6. S		e (In yrs. last birthday,	If Under 1 Year	If Under 24 Hrs.	8. Date of B	irth .		thplace (State or Foreign
L	Funeral Director			□M 2\\ F	90 Yrs.	Months Days	Hours Min.	8. Date of B (Month, D Septe	mber	16 E	
	<b>p</b> .		Usuel Residence of Decedent					2000	1915		· · · · · · · · · · · · · · · · · · ·
	arylar show	-	10a. State 10b. County		10c. City, Town or L	ocation					10d. Inside City Limits 1 ☑ Yes 2 ☐ No
	Ba-f	Director	MD Montgom	ery	Silver				10.00		
	with ti	吉	10e. Street and Number			10f. Zip Code				en of What Co	,
	9ath	Funeral	12001 01d Co1u	mbla Pik		20904	dispanic Origin? (Sp	acify Yes or N		ed Sta	
	ter d	'n	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☒ N		If Yes, specify Cub	an, Mexican, Puerto	Rican, etc.)		Black, White	
980	urs al	by	3 X Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2X No	Specify:			ipecify:	adorian
Ŏ	2 ho	ted	15. Decedent's Ec		16a. Dece	edent's Usual Occup	pation	rina		of Business/	
21215-0036	itied within 72 hours after death with the Maryland Hygiene. ther then "natural", or iteme 23a or 28a-1 show ther then "natural", or iteme 23a or 28a-1 show int, the Madical Examinar must be instiffed at	Completed	Elementary/Secondary (0-12)	College (1-4or 5	+) life.	DO NOT use retire	during most of work d)	9			
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Maryland	be fi	Be	17. Father's Name (First, Middle, Last)	,				,		umame)	
ž	should nd Men marke umatic	5	Pablo Aragon  19a. Informant's Name/Relationship (	Type Print)	10b Mail	ing Address (Street	Eladia and Number or Rur			Town State	Zin Code)
Ma	d 2 s th an th an traur		Maria E. Alva	•					-		20832
	1 and Health tem 27 other tr		20a. Method of Disposition	Lez	20b. Place of Disp cemetery, cre	osition (Name of	ey Brid	Date		1112 y ation - City or	Town, State
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: it item 27 is marked other than "natural; or iteme 23a or 28a-f show any injury or other traumatic event, the Madical Examinist must be notified at ance.		1 🕅 Burial 2 □ Cremation 3 □ 4 □ Donation 5 □ Other (Specif				P 1		E1 C	n 1 *** d	
₹	nit. F bartmoortar ortar injur	-	21. Signature of Funeral Service Licer			2. Name and Addre	den 200 ess of Facility Mus			alvad al Ho	ore 20011
Ã	permit. Departrimports eny inji		Whillin !	Boll &	4	804 Geoi	rgia Ave	. NW	Washi	ngton	, DC
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	/Medical		resulting in death)	Due to (or as	a consequence of):	1 - w/cs	10				
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P.O. Box	death certificate is executed e attending physiten and dor use as the builal-transit	by Physician/Medical	Cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	c. Due to (or as: d. Due to (or as: d. Live birth 4 Pregnant at 9 Unknown	a con, q, nce of):  Of pregnancy 2   Fetal death time of death 5	□Ectopic pregnanc □ Other (specify) _	у	1	tobacco use	Month  contribute to	ivery Day Year  the cause of death?
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P.O. Box	Hospital or Attending Physician. The law requires that the death certificate is executed 4 hours after death. Funeral Director: After this certificate has been signed by the attending physician and ety tilled in by the funeral director, page 2 should be detached for use as the funial-transit	edical Certification; To Be Completed by Physician/Medical	Cause, Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	c. Due to (or as:  d. Due to (or as:  d. Due to (or as:  d. Due to (or as:  d. Due to (or as:  light as:  light as:  d. Due to (or as:  light a	of pregnancy 2 Fetal death 31 time of death 5  ut not resulting in the control of	DOA Other (specify) underlying cause give  underlying cause give	yen in Part I.  26. Place of Deal ner: 4 \( \text{Nursing He rk?} \) Yes 2 \( \text{No} \) No	24a. Wa autroper 1 Ves th (Check only ome 5 Res 28d. Describe 28f. Location City or To	s an opsy formed? No one) sidence 6 (Street and own, State) s cause(s) ale, date and p	Month  e contribute to  No 3 pr  24b. Were au prior to death? 1 Yes  Other (Specoccurred)	ivery Day Year  the cause of death?  tobably 4 Unknown  utopsy findings available completion of cause of  2 No  city)  ural Route Number,
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14.	7 6 s	ने ८	1. Decedent's Name (First, I	Middle, Last,	)						2. Date of Dea	ath Day	Year	3. Time of D	eath
	Physicia /Medic	_	Khadija A	jami							Ju1y	02,	2006	10:35	a <sup>M</sup>
	Examin		4a. Facility Name (If not insti	-				4b. City, Town,		of Death			unty of Death	01800-	
2.3			Gladys Spel: 5. Social Security Number	Lman H		7. Age (In yrs.	last hirthday)	Chever		r 24 Hrs.	8. Date of Birt		nce Ge		Foreian
90.5	Funeral Director		194-62-0055	1	M 2⊠F	7. Age (III yrs.	50 Yrs.	Months Days		Min	8. Date of Birt (Month, Da July 4	, Year) 1956	Sien	olace (State or a ntry) ra Leor	ie
-3,			Usual Residence of Decede												
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5	72 h	Completed	15. Dec (Specify only I	edent's Edu highest grad	ication le completed	)	(Give	dent's Usual Occu kind of work done DO NOT use retire	during mo	st of workin	ng	16b. Kind	of Business/Ir	idustry	
121	within ane. then	mp	Elementary/Secondary (0	-12)	College 5+	(1-4or 5+)	Nur		<i>au)</i>			Hos	spital		
d 2	filed within 72 hours after death with the Maryland Hygiene. other than "natural", or Itema 23a or 28a-f show ent, the Medical Exammer onthis to notified at		17. Father's Name (First, Mi	ddle, Last)					18. Moth	ner's Name	(First, Middle,				
Maryland 21215-0036	lid be in the lental liked o	To Be	Sadique Aja	ami					Ма	rie F	'atu Ba	ngura			
ary	shou s mai		19a. Informant's Name/Rela	ationship (T)	уре, Print)			ng Address (Stree							
	and 2 salth a n 27 l		Mohammed Sar	nnoh /	Son		_	Heather							
ore	Pages 1 nent of He ant: If Iter ary or oth		20a. Method of Disposition  1XXBurial 2 ☐ Crema	ation 3 □F	Removal from			sition (Name of matory or other pl			ate		ion - City or T		
Baltimore,	tment tant:		4 □Donation 5 □ Oth	ner (Specify)	4 _	Ft.		1n Cemet			2006	Brent	wood,	Marylar	ıd
Bal	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural; or Items 23a or 28a-f show amortant: If item 27 is marked other than "natural; or Items 23a or 28a-f show in my hjury or other traumatic event, the Madical Examiner must be notified at once.		21. Signature of Fur ral Se	Troch	- The	y	Si 10	2. Name and Add mple Tri 40 Rockv	bute ille	Funer Pike;	Rockv:	ille,	tion ( Maryla	nd 2085	
sk.			23a. Part1. Enter the disea shock, or heart failure	se, or comp List only o	lications that ne cause on	caused the dea each line.	th. Do not en	ter the mode of dy	ring, such a	s cardiac o	r respiratory a	rrest,		Approximate Interval Betwo Onset and De	een
變	Physician		Immediate Cause (Final disease or condition resulting in death)	-	a	static		ancer					-	3 year	S
4	/Medical Examiner		,		Due to	o (or as a consec	quence of):								
ķ.	Rest.	-e	Sequentially list conditions, if any, leading to immediate		b. Due to	o (or as a conse	quence of):								
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oʻ	te be executed ysicien and e burial-transit	Ex	resulting in death) Last		Due to	(or as a conse	quence of):								
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o.	the d by the	ıysi	1 □ Yes 2 😿 No 9 □ Unknown		9□Unk	nown		27							
٥,	The law requires that the death certiticate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burial-transit	by Physician/Med	Part II. Other significant co			death but not re	sulting in the u	inderlying cause g	jiven in Par	t I.	23e. Did t	obacco use	contribute to	the cause of de	ath?
ğ	w require been signature	ed	Respiratory	tailur	e						10	Yes 2□1	No 3 ☐ Pro	bably 4X U/	nknown
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o To	Attending Physician: The lay reasth. cleath. sctor: Atter this certificate has by the tuneral director, page 2	- L	1 Yes 2 No 27. Manner of Death		1 L		ER/Outpatie	111 3L DOA	4 (2)(1		me 5 Resi 28d. Describe			fy)	
on	ding th. Atte	ig ig	1 ☑Natural 5 ☐ F	Pending nvestigation	(Mo	e of Injury nth, Day Year)	Injury		ork? ]Yes 2[						
Division	in Signature	ertification;	3 ☐ Suicide 6 ☐ 0	Could not be determined	288. Plac	ce of Injury - At I ding, etc. (Spec		reet, factory, office	9		28f. Location ( City or To		lumber or Ru.	al Route Numb	107,
	To the Hospital or Attentwithin 24 hours after deatl To the Funeral Director: completely tilled in by the	dical C	29a. Certifier 1 to Certifier (Check ont) 2 Me	rtifying Phy dical Exam	ysician: To the iner: On the and ma	ne best of my kn basis of examin oner stated.	nowledge, dea nation and/or in	th occurred at the ovestigation, in my	time, date of opinion, de	and place, eath occurr	and due to the ed at the time,	cause(s) ar date and pl	d manner as ace, and due	stated. to the cause(s)	
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	3)		30. Name and address of p					Print)	hever	1y, M	aryland	1 2078	5		
	St. Regist	ate rar	31. Date filed (Month, Day,	Year)		Redictrar's Side					<i>y</i>				

			1 - For State Registrar	State of	Marylar	nd / Dep <i>Ce</i>	artme e <i>rtifica</i>	nt of H te of L	ealth a Death	and M	ental		iene2 (	06	2332	27
			1. Decedent's Name (First, Middle, L	ast)							2. Date Mont	of Death	n Day	Yeer	3. Time of Dea	th
	Physici /Medic		Isaac Aboud								Jul	y 9,	2006	1001	10:14	э М
	Examin		4a. Fecility Name (If not institution, g	ive street and num.	ber)		4b. City	, Town, or	Location	of Death			4c. Count	y of Deat	h	
			Holy Cross Hospit	al			1	lver S		O			Montg	gomei	У	
	Funeral		Social Security Number     6.	Sex 7	. Age (In yrs.	V	/ If Und	or 1 Year Days	If Under Hours	Min.	8. Date (Mon	th, Day,	Year)	Co	hplace (State or For untry)	eign
	Director		088-20-0364	TIZALIWI ZUF		79 Yrs.					Mar	14,	1927	New	York	
	and *		Usuel Residence of Decedent  10a, State 10b, County		10c. Ci	ty, Town or I	ocation								10d. Inside City Lie	nits
	Aarylan Febow	ō	Maryland Montgome	<b></b>	Gai	thers	ourg								1 ☐ Yes 2 <b>X</b>	No
	28a-	ect	10e. Street and Number	JI y				ip Code				10	og. Citizen of	What Co	untry?	
	with Mary	₫	14734 Chisholm La	inding Wa	s.		208					T	JSA			
	death with the Maryland ms 23a or 28a-f ehow	Funeral Director	11. Marital Status	12. Was Deced	ent Ever in L	J.S. 13	. Was Dec	edent of Hi	spanic Ori	igin? (Spe	city Yes	or No-	14. Ra		rican Indian,	
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220	el', o	þ	3 Widowed 4 Divorced	ff Yes, Give Year or Dai	es: 1944	-45	1 🗆 Yes	21 <b>X</b> No	Specify:				Speci	w. Wh:	ite	
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and	iid be filed within 72 hours after lental Hygiene. ked other than "natural", or Ite ic event, Ina Madical Examina	Be	17. Father's Name (First, Middle, Las	st)	۸ 1			,			(First, N	tiddle, N	faiden Sumai	71 <b>0</b> )	(unk)	
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<u>a</u>	2 sh and is m		19a. Informant's Name/Relationship				_						City or Town		MD 20878	
2 (5)	and Health im 27 her t		Ronia G. Aboud/wi	re	20h	Place of Disp			Land		way		Oc. Location			
0	if it of the state or of		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3			cemetery, cr	ematory or	other place								
	t. Pa tmen tant: tjury		4 Donation 5 Other (Spec	- /	Ch	esapea				07/1					Maryland	<u>1</u>
Бант	permit. Pages 1 and 2 should be fited within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Because if them 23 a or 28a-1 ehow many injury or other traumatic event, the Maulical Examinar mail be notified at once.		21. Signature of Funeral Service Lice	Holi	MO1	251 E	Soing Bever	Home Ly L.	"Crem Heck	atio	n Se e, P	rvic	e P.C Clarks	o. Bo	ox 784 Le, MD 210	)29
	Physician		23a. Part1. Enter the disease, or co shock, or heart faifure. List on fmmediate Cause (Final disease or condition	mplications that ca y one cause on ea Sepsi	ch line.	th. Do not e	nter the mo	ode of dying	g, such as	cardiac o	r respirat	tory arre	st,		Approximate Interval Between Onset and Death	1
	/Medical		resulting in death)	Due to (o	r as a consec	quence of):										
	Examiner		Sequentially list conditions,	b. Pneum		<u>-</u>										
	si ad	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (o	r as a consec	quence of):										
	end end I-tran	хап	that initiated events resulting in death) Last	c	r as a consec	uence of):										
g/60,	ficate be executed physicien end as the burial-transit	alE				, , , , , , , , , , , , , , , , , , , ,										
ρα	phys s the	dical	(18)	d												
×	the death certificate be executed y the attending physicien end iched for use as the burial-transit	lan/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outc									23d. Da	ite of del	verv	
DOX	atter for u	clar	in the past 12 months?		th 2□Feta nt at time of a		☐ Cther (							onth	Day Year	
į.	the cy the achec	Physicia	9 Unknown	9□ Unknov	vn											
T.	requires that the de een signed by the a hould be detached f	by P	Part II. Other significant conditions	contributing to dea	th but not res	sulting in the	underlying	cause give	n in Part I	•	23e.	Did tob	acco use con	tribute to	the cause of death	?
cords,	quire n sig uld b	β	Dementia, Coronar	y Artery	Disea	se						1 🗌 Ye	s 2X No	3 □ Pr	obably 4 Unknown	own
ပ္ပ	: The law require cate hes been sig , page 2 should b	Completed									24a.	Was an		Were au	topsy findings availa	able
Ē	The Iz	E									100	autopsy perform Yes 2	ed?	death?	completion of cause 2□ No	OI
	iician: Th certificate rector, pag	0	25. Was case referred to medical						26. Place	of Death					20110	
	Physician: r this certific ral director,	To B	examiner? 1 ☐ Yes 2 ☐ No	Hospitaf: 1 ☐ fn	patient 2X	] ER/Outpatio	ent 3 [	Othe	or: 4 □ Nu	irsing Hon	ne 5 🗆	Reside	nce 6 Oti	ner (Spe	aty)	
0	g Ph ter th neral		27. Manner of Death	28a. Date of	Injury , Day Year)	28b. Time Injury		28c. Injury Work	at	2	28d. Des	cribe ho	w injury occu	red		
UIVISION	ath. r: Aff	atlo	1 Naturaf 5 Pending 2 Accident investigat	on	,,,	,,	М		res 2□	No						
<u> </u>	al or Attending Physician: s after death. I Director: After this certific id in by the funeral director,	Certification:	3 Suicide 6 Could not 4 Homicide determine	d 286. Place	of fnjury - At h g, etc. (Speci	iome, farm, s	treet, facto	ory, office		2	28f. Loca City	tion (Str	eet and Num State)	beror Ru	ral Route Number,	
5	rs aft	Cer														
	To the Hospital (within 24 hours a To the Funerel Completely filled i	Medical		Physician: To the bandiner: On the band manner	sis of examina											
	To the To the Complet	Me	29b. Signature and title of certifier				2	9c. License	number	00		29	d. Date signe			
_			I XIXIII	1				D4	45	7	)		07-	10-	-66	
12	00			o completed cause					,							
2				nio M.D.			Glen	Rd.	Silve	er Sp	ring	, MD	20910	)		
efe	Sta Registr		31. Date fied (Month, Day, Year)  JUL 1 2		gistrar's Sign		brack	,								

			1- State of Maryla		artment of rtificate or			ene	06	23328
			Decedent's Name (First, Middle, Last)				2. Date of Death			3. Time of Death
	Physici /Medi		CLIFFORD M. ABEL				Month	Day / ()	Year	12: 05 PM
	Examir		4a. Facility Name (If not institution, give street and number)		4b. City, Town,	or Location of Death		4c. County	of Death	
			533 Stoney Battery Rd.		Ear1e	ville		C€	ci1	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yr 069-32-6371 12 M 2 F 64	s. last birthday) Yrs.	If Under 1 Yea Months Days		8. Date of Birth (Month, Day,		9. Birthp Coun	lace (State or Foreign try)
			Usual Residence of Decedent				DEC 20	1941	New	York
	ylanc now		10a. State 10b. County 10c. (	City, Town or Lo	ocation				1	0d. Inside City Limits
	a-f sl	tor	DE New Castle W	ilming	ton					1 ☐ Yes 2📆 No
	or 28	lre	10e. Street and Number		10f. Zip Code		100	g. Citizen of \	What Coun	try?
	23a	a	119 Carpenter's Row		1980	7		U.S.A		
	r dez	Funeral Director	11. Marital Status 12. Was Decedent Ever in Armed Forces?		Was Decedent of	Hispanic Origin? (Spo ban, Mexican, Puerto	ecify Yes or No-	14. Rac	e - Americ	an Indian,
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or othar traumatic event, "I'm Medical Exam as must be notified at once.	by Fu	1 □ Never Married 2 🕱 Married 1 🕏 Yes 2 □ No If Yes, Give View or Dates: View	tnam	1 ☐ Yes 2 🌠 No		r noun, oto.,	Specify		nite
21215-0036	2 hou atura	ed	15. Decedent's Education		dent's Usual Occu	ination	146	Sb. Kind of Bi		
7	nin 72 in "ni	Completed	(Specify only highest grade completed)  Elementary/Secondary (0-12) College (1-4or 5+)	(Give	kind of work done DO NOT use retir	e during most of working)	ing	D. KING OF BO	12111622/1110	lustry
21	d with	E O	5	Direc	tor of	Constru	ction	Banki	na/E	inance
	al Hy tothe vent	Be	17. Father's Name (First, Middle, Last)			18. Mother's Name	(First, Middle, Ma			
<u>Xa</u>	Menta Menta arked	To	Clifford M. Abel, Sr.			Margare	t Peter	son		
Maryland	2 sho		19a. Informant's Name/Relationship (Type, Print)			at and Number or Rura				
	l and lealth im 27 har t		Gertrude E. Abel (wife)		-	ter's Ro		ingto		
Baltimore,	it of F		1 Burial ~2 TyCremation 3 Removal from State		natory or other pla	ace)		c. Location -		
₫	it. Partmer rtmer rtant njury		'4 □Denation 5 □ Other (Specify) HO			atory 7/	14/06 W	i1min	gton	DE.
Ba	Departiment of the post of the		M005	. Ch	Name and Addr andler	Funeral	Homes	& Cre	mato	ry
			23a, Part T. Enter the disease, or complications that caused the dea	10 25	06 Con	cord_Pik	e Wilm	inata	n, D	F. 19803 Approximate
	4		shock, or hear failure. List only one cause on each line.	0	or the mode or dy	ing, sadir as cardiac o	i respiratory arres	L,		Interval Between Opset and Death
	Pnysician /Medical		disease or condition resulting in death)	-	anc	ev				1 month
Н	Examiner		Due to (or as a conse	quence on:						
		Jer	Sequentially list conditions, if any, leading to immediate Due to (or as a consecuence Server Linderthins	quence of):						
	cuted nd ransi	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events  C.							
Ö,	e exe ian ai urial-t	EX	resulting in death) Last Due to (or as a conse	quence of):						
8760,	ficate be executed physician and is the burial-transit	dlcal	d							
9	ertific ling p		IF FEMALE:			_				
Вох	death certifii e attending p ed for use as	ian/	23b. Was decedent pregnant in the past 12 months?	tal death 3 🗆	Ectopic pregnanc	ęy		23d. Date Mor	of deliver	y Day Year
o.	0 0 9	Physician/Me	1 ☐ Yes 2 ☐ No 4 ☐ Pregnant at time of 9 ☐ Unknown 9 ☐ Unknown	death 5	Other (specify) _			14101		Say Toa.
٥.	res that I igned by be deta	/ Ph	Part II. Other significant conditions contributing to death but not re	sulting in the un	derlying cause gr	ven in Part I.	23e. Did tobac	co use contr	ibute to the	cause of death?
rds,	- v - l	d by			, , ,			_		bly 4 □Unknown
Record	s been should	olete					24a. Was an	24h W	Jore autori	sy findings available
	9 2 9	Completed					autopsy performe	d?	rior to com eath?	pletion of cause of
Vital	ician: Th certificate rector, pag	a)	25. Was case referred to medical			26. Place of Death		10 1	☐ Yes 2	2 LJ No
	ly s	ToB	examiner? 1 ☐ Yes 2 ☐ No Hospital: 1 ☐ Inpatient 2 ☐	] ER/Outpatient	3□ DOA Ot	hor	ne 5 Residence	e 6 Othe	r (Specify)	2nd home
0	gr en		27. Manner of Death 1 ☑Natural 5 ☐ Pending (Month, Day Year)	28b. Time of Injury	28c. Inju Wo		8d. Describe how			zno nome
0	Attending or death. actor: After by the fune	Satle	2 Accident investigation			Yes 2□No				
Division of	o ir	ertification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At the building, etc. (Spec	nome, farm, stre	et, factory, office	2	8f. Location (Stree City or Town, S	t and Numbe state)	r or Rural	Route Number,
	Hospital of the same of the sa	0	29a. Certifier 1 Certifying Physician: To the hast of my kn							
	7 4 7 8	edical	29a. Certifier  (Check only one)  2	owledge, death ation and/or inv	occurred at the ti estigation, in my	me, date and place, a opinion, death occurre	nd due to the caus d at the time, date	e(s) and mar and place, a	ner as stai nd due to t	ted. he cause(s)
	To the Hos within 24 h To the Fur completely	Me	29b. Signature and title of certifier		29c. Licens	se number	29d.	Date signed	(Month, Di	ay, Year)
	. >1-0		Yal -	M	DN	1056VL	19	7/11/	06	<b>,</b>
		1	Name and with ss of person who completed cause of death (Ite	m 23.) (Type, F	rint)	7 / 2	2/1/	/   /		
K	STIVA		dovia Dimonson MD III We	5/119	h5+.5	uite 202	Elkta	1 MD	219	12/
	Sta Registra	_	31. Date filed (Month, Day, Year) 32. Reoftrar's Sign	ature	books					
1	3		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,							

			For State Registrar		State	of Maryl		•	rtment of H Hificate of I	lealth and N Death	lental Hy	giene Reg. No.	2006	23329
			Decedent's Name (First, in the content of the	Middle, Las	st)						2. Date of De	eath Day	Year	3. Time of Death
	Physicia /Medic		Susan Kin	ser	Baucia						July	8 "	2006	10:46 A M
1	Examin		4a. Facility Name (If not inst	titution, give	e street and nu	ımber)			4b. City, Town, or	Location of Death			County of Dea	
			Anne Arunde	l Med	ical Ce	enter			Annar				nne Aru	
	Funeral		5. Social Security Number	6. S	ex □M 2[ <b>X</b> F		yrs. last birth		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bi	av. Year)	C	thplace (State or Foreign ountry)
	Director		504-46-5710				63 <sup>Y</sup>	rs.			Aug. 8	, 19	42 Inc	diana
	and		Usuel Residence of Decede  10a. State 10b. Co			10c.	City, Town	or Loc	ation					10d. Inside City Limits
	Maryl feb	ō	MD Ann	e Aru	മർവ		C	roft	-on					1 XYes 2 ☐ No
	28a	Tec.	10e. Street and Number	e ALU	IMCI		<u>C1</u>	LOL	10f. Zip Code			10g. Citiz	zen of What Co	ountry?
	3a or	<u>a</u>	1241 Martha	Gree	nleaf I	or.			2	1114			USA	
	within 72 hours after death with the Maryland ene. than *natural; or iteme 23a or 28a-f ehow ha Madical Examiner must be notified at	Funeral Director	11. Marital Status	OLCC	12. Was Dec	edent Ever i	n U.S.	13. W		lispanic Origin? (Sp an, Mexican, Puerto	ecify Yes or No	o	14. Race - Ame	
و	or ite	ᆵ	1 Never Married 2	Married	Armed F	2 🔯 No			Tes, specily Cuba ☐ Yes 21X No	Specify:	nican, etc.)		Black, White	te, etc.
ğ	rai', c	l by	3 Widowed 4 Div	orced	If Yes, G Year or I	Dates:							Specify. W	hite
21215-003	72 ho	Completed	15. Dec (Specify only)	cedent's Ed highest gra		)	16a. l	Decede (Give k	ent's Usual Occup	ation during most of work d)	ing	16b. Kii	nd of Business	/Industry
2	ithin ne.	d.	Elementary/Secondary (0	-12)		(1-4or 5+)				3)		E-21	ucation	
	lygier her ti	8	17. Father's Name (First, Mi	iddle Last		5+		.T.6	eacher	18. Mother's Nam	e (First Middle			1
Maryland	be fi	Be									ret Huli		<i>Domamo</i> ,	
2	d Mer nark	ဥ	Maurice Wi		Tune Print)		19h	Mailine	Address (Street	and Number or Rui			Town State	Zin Code)
a N	d 2 sh h and 7 le r traur		_							reenleaf		-	on, MD.	
	1 and Healthean 2 ther		Anthony Bauc  20a. Method of Disposition	1a /	spouse	20			ition (Name of atory or other place		Date		cation - City or	
Ö	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Heatth and Mental Hygiene. Important: if item 27 ie marked other than "natural", or iteme 23a or 28a-f ehow eny injury or other traumatic event, the Madical Examiner must be notified at one.		1 ☐ Burial 2 ☐ Crema 4 ☐ Donation 5 ☐ Oth			i State				atory 07/	10/2006	۸۱۵	vandri a	177
Baltimore,	ortme ortan injury		21. Signature of Funeral Se			171	ectob			ss of Facility Be				I, VA.
B	Depermine Depermine Important in processions of the procession of the	6 0	PR	5	You	eoll	)	1		rain Hwy.		e, M		'15
			23a. Part1. Enter the disea shock, or heart failure	se, or com	plications that	caused the c	death. Do n					<del>-</del>		Approximate Interval Between
	Physician	į	Immediate Cause (Final	. List only	One Cause on	1 1	CHA	i	les	ra Co	ncep			Onset and Death
	/Medical		disease or condition resulting in death)	-	a. Due to	(or as a con	sequence o	f);		)				0
	Examiner		O	- 1	h									
	B =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	•	Due to	(or as a con	sequence o	f):						
	acute and trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	1	c			45.						
, 0,	e exe	ũ	resulting in death) cast	- 1	Due to	(or as a con	isequerice o	1);						
8760,	ficate be executed physicien and is the burial-transit	dicai		•	d									
Θ	ding p		IF FEMALE:		23c. If yes, or	utcome of pre	egnancy						23d. Date of de	livery
Bo	leath certifi attending I for use es	cian	23b. Was decedent pregna in the past 12 months'		1□Live	birth 2 1	Fetal death		Ectopic pregnancy Other (specify)	1			Month	Day Year
.O. Box	the d	ıysi	1 ☐ Yes 2 █ No 9 ☐ Unknown		9□ Unki									
<u>α</u>	The law requires that the death certifi Ne has been signed by the attending bage 2 should be detached for use es	by Physician/Me	Part II. Other significant co	onditions o	ontributing to	death but not	resulting in	the un	derlying cause giv	en in Part I.	23e. Did	tobacco u	se contribute t	o the cause of death?
g	quires n sign										10	Yes 2	]No 3∏P	robably 4 Unknown
00	w require been signature should b	Completed									24a. Was		24b. Were a	utopsy findings available
Re	The lay	E O									auto perfe	psy ormed? 2 18 No	death?	completion of cause of s 2 \( \subseteq \text{No} \)
ta		0	25. Was case referred to m	edical	8					26. Place of Dear				
$\geq$	S 0 T	To B	examiner?		Hospital:	Inpatient	2 ER/Out	patient	3 DOA Oth	er: 4 🗆 Nursing Ho	ome 5 ☐ Res	idence 6	S □Other (Spe	ecify)
0	ding Phy h. After thi funeral o		27. Manner of Death 1 SNatural 5 ☐ F	Pending	28a. Date (Mo	of Injury oth, Day Yea	28b. Ti	ime of	28c. Injur Wor	y at k?	28d. Describe	how injur	y occurred	
Ö	andin aath. or: Af	atic	2 Accident	nvestigation						Yes 2 ☐ No				
Division of Vital Records,	or Atter de Directe in by the	Certification:	3 ☐ Suicide 6 ☐ 0	Could not b determined	200. Flac	e of Injury - ding, etc. (Sp	At home, far <i>ecify)</i>	m, stre	et, factory, office			Street and wn, State,		ural Route Number,
	ital o				W.									
	Hospital 24 hours a Funerel ( tely filled	edicai	29a. Certifier 1 Ce (Check only 2 Me	ortifying Prodical Exam	niner: On the	basis of exam	knowledge, mination and	death Vor inv	occurred at the tir estigation, in my o	me, date and place, pinion, death occur	red at the time.	date and	and manner a place, and du	s stated. e to the cause(s)
	To the Hospital or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Med	29b. Signature and title of	ertifier	anu ma	nner stated.			29c. Licens	se number		29d. Dat	e signed (Mon	th, Day, Year)
	Z Z Z S		+ AMANAIL	l,	1 121	ent	ta u	1	n	211	138	Sh	ila.	10 Jan
il.	10		30. Name and address of p	erson who	completed car	use of death	(Item 23a) (	Type. F	Print)			-0	1	1006-
,	10		Michael J. I				5 Defe			Annapoli	s, MD.	214	401	
	Sta	te	31. Date filed (Month, Day,	Year)		Registrar's S			<b>4</b> , -					
		ar	JUL 1 0 2	.006	Malue	1	A CONTRACTOR OF THE PARTY OF TH							

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) Date of Death
 Month 3. Time of Death Dav Year **Physician** LUTORIA BROWN 0350 00 2000 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner DOCTOR'S HOSPITAL PRINCE GEORGE'S LANHAM 5. Social Security Number If Under 1 Year | If Under 24 Hrs. 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) JULY 3 197 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 ☐ M 2 🖫 F **Director** 213-17-4348 27 Yrs. VIRGÍNIA Usual Residence of Decedent the Maryland 10a. State 10h Counts 10c. City, Town or Location 10d. Inside City Limits 28a-f ehow traumatic event, the Madical Examiner must be notified at Director N Yes 2 No PRINCE GEORGE'S BLADENSBURG 10e. Street and Number 10f. Zip Code 10g, Citizen of What Country? ŏ U.S.A. Items 23a 4207 58th AVENUE # 2 20710 Funera 12. Was Decedent Ever in U.S Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after 1 ☐ Yes 2X No If Yes, Give Year or Dates: 1 1 Never Married 2 ☐ Married ö 1 ☐ Yes 2 ☑ No þ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced "natural", Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Is marked other than Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. 12th NONE NONE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental DWIGHT G. ATCHERSON CHRISTINE ပ BROWN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Important: If Item 27 Is: DWIGHT G. ATCHERSON/FATHER 3711 COOPER LANE HYATTSVILLE, MARYLAND 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State HARMONY CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 7/10/2006 LANDOVER, MARYLAND 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final 1210 Pnysician disease or condition resulting in death) /Medical Due to (or a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a cons nence of): Examiner physician and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760. Physician/Medical nding r IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy ō in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. F ed by the a detached f ☐Yes 2☐No 9 Unknown 9 Unknown ed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, Completed by been signe should be 3 Probably 4 Unknown 1 ☐ Yes 2 ☐ No 24b. Were autopsy findings available prior to completion of cause of death? 24a Was an autopsy performed? 1 Yes 1 ☐ Yes 21 No Division of Vital or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital Other: 4 Nursing Home 5 Residence 6 Other (Spealty) 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of Injury Medical Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation To the hosping within 24 hours after death.

To the Funeral Director; Aft 1 ☐ Yes 2 ☐ No 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) MDD 59993 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Main St., Ste 253, Laurel, mo 20707 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUI 11 Registrar

ORIGINAL

			1- State of Maryland / Department / Department / Departmen	artment of Health and Martificate of Death		iene g. Nd. 006	23331
			Decedent's Name (First, Middle, Last)		2. Date of Death Month	1	3. Time of Death
	Physici: /Medic		AARON K. BERKLEY		JULY	5 2006	2:52 P M
	Examin		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death		4c. County of Deat	
			WASHINGTON ADVENTIST HOSPITAL	SILVER SPRING  If Under 1 Year   If Under 24 Hrs.	S. Data of Birth	MONTGOME	
	Funeral Director		5. Social Security Number 577-68-2809 6. Sex 1 M 2 F 7. Age (In yrs. last birthday) Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day, SEPT . 1	Year) 9. Bin. Co	hplace (State or Foreign untry)
			Usual Residence of Decedent		SEFI. I	0 1949 WAS	HINGION, DC
	show	_	10a. State 10b. County 10c. City, Town or Lo	ocation			10d. Inside City Limits
	death with the Maryland ms 23a or 28a-f show Fritual Ev notificed at	Director	MD MONTGOMERY TAKOMA				1X Yes 2 □ No
	with th	Dire	10e. Street and Number	10f. Zip Code	10	og. Citizen of What Co	untry?
	eath 's 23	eral	7620 MAPLE AVENUE # 202  11. Marital Status 12. Was Decedent Ever in U.S. 13.	20912 Was Decedent of Hispanic Origin? (Spec	cify Yes or No-	U.S.A.	rican Indian
30	3 within 72 hours after death with the Maryla jiene, Itan, "natural", or Itams 23a or 28a-1 shov The Medical Examinar Irans to notified at	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2X No	Was Decedent of Hispanic Origin? (Speilf Yes, specify Cuban, Mexican, Puerto F  1 ☐ Yes 2 ☑ No Specify:	Rican, etc.)	Black, White	
15-0036	2 hour	ed k	15, Decedent's Education 16a, Dece	dent's Usual Occupation	1	16b. Kind of Business/	Industry
ر 15	within 72 ene. than "na!	plet	(Specify only highest grade completed) (Give	kind of work done during most of workin DO NOT use retired)	ng		,
7	ad with	Completed	12th COME	PUTER TECHNICAN		PRIVATE	
Maryland	be filed stal Hygi od other event, t	Be	17. Father's Name (First, Middle, Last)	18. Mother's Name GENEVA	(First, Middle, M HARRIS	faiden Sumame)	
<u> </u>	2 should be f and Mental I le marked of reumatic eve	ပို	BURDOCK BERKLEY  19a. Informant's Name/Relationship ( <i>Type, Print</i> )  19b. Mailin	ng Address (Street and Number or Rural		City or Town State 7	Zin Code)
	무를 놓			MAPLE ACVE. # 202			
Baltimore,	e = 5		20a. Method of Disposition 1   ■ Burial 2 □ Cremation 3 □ Removal from State  20b. Place of Disposition cemetery, crei	matory or other place)		20c. Location - City or	
			`4 □ Donation 5 □ Other (Specify) HARMONY  21. Signature of Funeral Service Licensee ,	CEMETERY 7/13/		LANDOVER,M KINS FUNER	
g	permit. Departi Import any inj			474 LANDOVER ROAD			
			23a. Part1. Enter the disease, or complications that caused the death. Do not ent shock, or heart failure. List only one cause on each line.				Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	Vascular A			Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):				
		ner	Sequentially list conditions, in any, leading to immediate cause. Enter Underlying Cause. Disease or injury				
	the death certificate be executed y the attending physician and iched for use as the buriat-transit	Examiner	that initiated events c.				
/60,	be exician a burial	ai Ey	Due to (or as a consequence of):				
289	ficate p phys	edicai	d				
ŏ	eath certific attending p	n/M	IF FEMALE: 23b. Was decedent pregnant 1 □ Live birth 2 □ Fetal death 3 □	TE eta sia ara ananana		23d. Date of deli	ivery
n	a death he atte ed for	Physician/M	1 Yes 2 No	□Ectopic pregnancy □ Other (specify)		Month	Day Year
J.	that the de led by the detached		9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the u	nderhving cause given in Part I	23e Did tob	acco use contribute to	the cause of death?
ecords,	36 Dec	d by	Hypertensian	ridelitying cause given in Fait i.	1 49		obably 4 Unknown
Ö	w require been sign should b	Completed	Deap Venous Thrombosis		24a. Was ar		topsy findings available
r	The lav	omp	24-6 14.000313		autopsy perform 1 Yes 2	prior to d	completion of cause of
VItal		a	25. Was case referred to medical	26. Place of Death			25 NO
	nysici nis ce direc	To B	examiner? 1   Yes 2   No   Hospital: 1   Inpatient 2   ER/Outpatier	nt 3 DOA Other: 4 Nursing Hom	ne 5 ☐ Reside	nce 6 Other (Spec	cify)
n of	ding Ph h. After thi funeral		27. Manner of Death 1 → Natural 5 □ Pending 28a. Date of Injury (Month, Day Year) 28b. Time o	Work?	8d. Describe ho	w injury occurred	
<u> </u>	ttend death tor: /	icati	2 Accident investigation	M 1 Yes 2 No	Of Location /Str	eet and Number or Ru	eral Pauta Alumbas
DIVISION	al or Attendir after death. I Director: Af d in by the fu	Certification:	4 Homicide determined 28e. Place of Injury - At home, farm, str	eet, ractory, office	City or Town		rai noute vumper,
	o the Hospitel or Attending Physicien: Nain 24 hours after death. The Funerel Director: After this certific grippeterly filled in by the funeral director,	Medical C	29a. Certifier  (Check only one)  1  Certifying Physician: To the best of my knowledge, deat 2  Medical Examiner: On the basis of examination and/or in and manner stated.	h occurred at the time, date and place, a vestigation, in my opinion, death occurre	nd due to the ca	use(s) and manner as te and place, and due	stated. to the cause(s)
	Whin 2	Mec	29b. Signature and title of certifier  and manner stated.	29c. License number	29	d. Date signed (Month	n, Day, Year)
/	(5)		# Zymo ER	044848		7/5/0	6
(	200		30. Name and address of person who completed cause of death (Item 23a) (Type, Humaym Zey M.D.; Washington Adv		600 C	Parle m	the 20912
	Sta		31. Date filed (Month, Day, Year) 32. Registrar's Signature				
	Registr	aı	JUL 1 1 2006 Bleen & South				

State of Maryland / Department of Health and Mental Hygiene? Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death **Physician** Month BURGESS **EDWARD** SAMILET. JUNE 2006 30 5:55 P M /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 3600 TYROL DRIVE LANDOVER PRINCE GEORGE'S 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Days Hours 1⊠M 2□F Director 84 Yrs 577-60-7237 26 1921 VIRGINIA Usual Residence of Decedent with the Maryland 10a State 10b. Count 10c. City, Town or Location 10d. Inside City Limits or 28a-f show the Medical Examiner must be notified at Director 1X Yes 2 □ No PRINCE GEORGE'S SPRINGDALE 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? Items 23a 3600 TYROL DRIVE death v Funerai 20774 U.S.A. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Nes 2 No Army 1 Never Married 2 ☐ Married 1 Ayes 2 Army If Yes, Give Year or Dates 6/43 - 1/46 Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No Specify: Completed by Specify: 3 □XWidowed 4 □ Divorced **Black** "natural". 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry other then " Elementary/Secondary (0-12) College (1-4or 5+) 12th ADMINISTRATION GOVERNMENT traumatic event, permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 1e marked othe any Injury or other traumatic event, 9068. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) MAGGTE PARKS BURGESS 2 WALTER 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3600 TYROL DRIVE SPRINGDALE, MARYLAND 20774 SAUNDRA BURGESS/DAUGHTER 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/12/2006 CHELTENHAM, MARYLAND MARYLAND VETERANS 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of): Examiner Secuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed burial-transit Due to (or as a consequence of) Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery atten for us 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No Day Year 4☐Pregnant at time of death 5 Other (specify) detached o 9 Unknown 9 Unknown Division of Vital Records, P. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? Yes 2 1 No certificete 1 ☐ Yes 2 No 1 Yes r: After this certification of funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 XYes 2 ☐ No ျ 1 Inpatient 2 ER/Outpatient 3 DOA 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification; 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation Injury death. I Director: A 1 Tes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after To the Funeral Direct 4 T Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifies Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number D0007967 JULY 3, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 600 RIVERBENG RD. FT. WASHINGTON, MARYLAND 20744 ALBERT E. ROLLE M.D. 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 1 2006 Registrar

			1 - For State Registrar	State of Marylan	-	artment of F			Reg. No 2 U U 6	23333
	Physicia		Decedent's Name (First, Middle, Li     RICHARD JAMES I	-				2. Date of De Month July 6	Day Year	3. Time of Death 12:40 pM
}	/Medic Examin		4a. Facility Name (If not institution, gi			4b. City, Town, o	r Location of D		4c. County of Dea	
	Examin		7205 Oliver St	eet		Lanham			Prince 0	George's
	Funeral Director		037-26-7449	Sex 7. Age (In yrs. 1 1 ☑ M 2 ☐ F 63	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hours	Min. 8. Date of Bin (Month, Da Jan. 9,	th 19, Year) 1943 F10	thplace (State or Foreign ountry) rida
	yland now		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or Lo	ecation				10d. Inside City Limits
	a-fst	ctor	Maryland Prince	George's Lar	ham					1 ∑Yes 2 ☐ No
	with the	Funeral Director	10e. Street and Number 7205 Oliver Str	root		10f. Zip Code 20706			10g. Citizen of What C U.S.A.	ountry?
	eeth v	erai	11. Marital Status	12. Was Decedent Ever in U.	S. 13.		lispanic Origin	? (Specify Yes or No		erican Indian,
39	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Health and Mental Hygiene. Department of Health and Mental Hygiene. Insportant: if Item 27 is marked other than "natural; or items 23s or 28s-f show eny injury or other traumatic svent, the Medical Examinar must be notified all page.	þ	1 Never Married 2 X Married 3 Widowed 4 Divorced	Amed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		f Yes, specify Cuba 1 ☐ Yes 2 No		? (Specify Yes or No Juerto Rican, etc.)		te, etc. Vhite
21215-0036	72 hou	Completed	15. Decedent's I	Education rade completed)	(Give	dent's Usual Occup	durina most ol	working	16b. Kind of Business	/Industry
12	within ane. than	idm	Elementary/Secondary (0-12)	College (1-4or 5+) 4		no NOT use retired her/Sport	•	h	Education	1
2	filed Hygie other		17. Father's Name (First, Middle, Las		Teac	ner/spor		Name (First, Middle,		
<u>Ian</u>	uld be Vental Irked c	To Be	Jesse J. Brown				Josep	hine Lima		
Maryland	12 sho h and l 7 ls ma trauma	18	19a. Informant's Name/Relationship		1				er, City or Town, State, Maryland 20	
<u>6</u>	Healt Healt tem 2		Joyce A. Brown 20a. Method of Disposition			sition (Name of matory or other place	-	Date Date	20c. Location - City of	
<u>E</u>	Pages nent of nnt: ff I		1 X Burial 2- Cremation 3 4 Donation 5 Other (Spec	_nemoval from State		oln Cemeter	I I	/10/2006	Brentwood	, Maryland
Baltimore,	permit. Departr Imports eny inje		21. Signature of Funeral Service Life	Mag	1				uneral Home attsville,	
			23a. Part . Enter the disease, or cor shock, or heart failure. List only	nplications that caused the death	n. Do not ent					Approximate Interval Between Onset and Death
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	. Obstruction	n 0.	t Pha	ryny	<u> </u>		2-4 uks
	Examiner			Due to (or as a consequence of the consequence of t	uence of):	Head	Cerro	Nec 1	_	54VS
	D Æ	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence	uence of):	7 . 000	0.0	7000		0
Ċ,	ate be executed hysician and the burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a consequence	uence of):					
8760,	cate be ohysicia the bur	Icai		d						
Box 6	certifii nding p use as	√Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregna					23d. Date of de	livery
o.	The law requires that the death certifics lie hes been signed by the attending pt page 2 should be detached for use as it	Physician/Med	in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	1 □ Live birth 2 □ Feta 4 □ Pregnant at time of d 9 □ Unknown		Ectopic pregnancy Other (specify)	<i>'</i>		Month	Day Year
ds, P	luires that signed b	ρ	Part II. Other significant conditions	contributing to death but not res	ulting in the u	nderlying cause giv	en in Part I.		obacco use contribute t Yes 2 □ No 3 □ P	o the cause of death? robably 4 Denknown
Records,	e law requir hes been si je 2 should	Completed						24a. Was	an 24b. Were a	utopsy findings available completion of cause of
Œ =		Som						perfo	ormed? death?	
Vital	ilcian: Th certificete rector, pag	Be	25. Was case referred to nedical examiner?	Hospital:		oth Oth	0.00	Death Check only		
ō	는 등교	7: To	1 ☐ Yes 2 ☑ No 27. Manner Death	1 ☐ Inpatient 2 ☐  28a. Date of Injury (Month, Day Year)	ER/Outpatier 28b. Time o	" 3L1 DOX	4 🗆 INUISI		dence 6 Other (Spendown)	əcify)
ö	ath. r: After re funer	atio	1 ✓ atural 5 ☐ Pending 2 ☐ Accident investigati		Injury		k? Yes 2⊡No			
Division	al or Atta s after de: il Directo ed in by th	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine		ome, farm, str	reet, factory, office		28f. Location ( City or To	Street and Number or F wn, State)	lural Route Number,
	To the Hospital or Attant within 24 hours after death To the Funeral Director: completely filled in by the	Medical C		thysician: To the bast of my kno aminer: On the basis of examina and manner stated.						
	11	¥	29b. Signature and title of certifier	clull	W)-	29c. Licens	_		29d. Date signed (Mon	
	(10)	9	30. Name and address of person who	DOWSVIILY	MO 1239) (Tuna		7996	-	717/0	0
	yc		Eduav	d A. Sales	J.M.	MD.	Balt	South Gree timore, Ma	ne Street ryland 2120	01
	Sta Registi		31. Date filed (Month, Day, Year)	32. Registrar's Signa	ture					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup>**2006 Physician** July 3, William Francis 3:15 P. M Brown /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death **Examiner** Randolph Hills Nursing Home Wheaton Montgomery If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | 1922 | 9. Birthplace (State or Foreign Months | Davs | Hours | Min. | (Month, Day, Year) | 922 | 9. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Months Days 1X M 2□ F September 13, Washington, D.C. Director 579-16-9004 83 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10b. County 10d. Inside City Limits 10a, State item 27 is marked other then "neturel", or items 23e or 28e-f show other treumetic event, the Medical Examiner must be notified at 1X Yes 2 □ No Director Maryland Montgomery Wheaton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 4011 Randolph Road 20902 United States Funeral 12. Was Decedent Ever in U.S Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 72 hours after ☐ Yes 2 No f Yes, Give 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify Specify: Black þ 3 X Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry is 1 and 2 should be filed within the Health and Mental Hygiene. ementary/Secondary (0-12) College (1-4or 5+) 10th grade Cemetery Groundskeeper Mount Olivet Cemetery 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Brown Williams Alice Mary 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20743 19a. Informant's Name/Relationship (Type, Print) Zina Deneen Hunter(Grand daughter) 1227 Larchmont Avenue; Capitol Heights, Maryland July 18,2006 20c. Location - City or Town, Slate 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition permit. Pages 1
Department of H
Importent: If itel
any injury or oth 1 M Burial 2 ☐ Cremation 3 ☐ Removal from State Resurrection Cemetery Clinton, Maryland \* 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility

R. N. Horton Company Morticians, Inc. 21. Sonature of Juneral Service 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Adenocarcinoma, Metastatic to Lung, Without disease or condition resulting in death) /Medical Examiner Known Primary Sequentially list conditions, any leading 15 immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine certificate be executed use as the burial-transit Due to (or as a consequence of) attending physician Box 68760 Physician/Medical IF FEMALE: If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. the 9 Unknown à signed to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 Unknown Completed been 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No autopsy 2X No 1 Yes Hospital or Attending Physicien: 24 hours after death. Funerel Director: After this certifice 25. Was case referred to medical 26. Place of Death (Check only one) examiner' Other: 4X Nursing Home 5 Residence 6 Other (Specify) 2 **X**No 1 Yes 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 🗆 DOA funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred Certification: 1 X Natural 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 🗌 Homicide 24 hours a Example 2 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated within 2. the 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 D52261 July 3, 2006 30. Name and address of person who completed cause of death (Item 23a) Type, Print) 1517 Hugo Circle; Silver Spring, Maryland 20906 Alan R. Segal, M.D.; 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 1 2006 JUL Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** 12:20A M BRADFORD SALLIE /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner PRINCE GEORGE'S DOCTOR'S HOSPITAL LANHAM If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, JULY 5 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 🖾 F 229-36-8696 Director 87 1918 VIRGINIA Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits or 28a-f show or other traumatic event, the Mudical Exandrier must be nutified at by Funeral Director 1 XYes 2 No PRINCE GEORGE'S BOWIE MD10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? U.S.A. 15005 HEALTH CENTER DRIVE Items 23a 20716 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-if Yes, specify Cuban, Mexican, Pueno Rican, etc.) 11. Marital Status 14. Race - American Indian Black, White, etc. 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married ŏ 1 ☐ Yes 2 No Specify: 3 ∰Widowed 4 ☐ Divorced BLACK "natural", Be Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important: If item 27 is marked other than "na any injury or other traumatic event, the Medic once. (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12th HOME MAKER PRIVATE 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) HENRY W. SANFORD SALLIE HOSKIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) TONEY/DAUGHTER 4910 DUBUN DRIVE SUITLAND MARYLAND CORINIA 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) FT. LINCOLN CEMETERY 7/5/06 BRENTWOOD, MARYLAND 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 21. Signature of Funeral Service Licensee 7474 LANDOVER ROAD LANDOVER, MARYLAND complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, only one cause on each line. 23a. Part1. Enter the disease, or shock, or heart failure. List Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** SEPTICEMIA /Medical Due to (or as a consequence of). Examiner RITON Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner or Attending Physician: The law requires that the death certificate be executed use as the burial-transit and Box 68760, attending physician IBRIL Completed by Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery ned by the atten detached for u 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 4 Unknown 1 ☐ Yes 2 ☐ No 3 Probably 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed certificate 1 Yes 2₺ No 1 🗌 Yes 2 ours after death.

nerel Director: After this certific filled in by the funeral director. Be 25. Was case referred to medical 26. Place of Death Check only one examiner' Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 2 1 Tes 1 Inpatient 2 XER/Outpatient 3 DOA 27. Manner of Death Certification: 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 Tes 2 No 2 Accident investigation 3 🗌 Suicide 6 Could not be determined Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a
To the Funerel C
completely filled To the Hospitel 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 29a. Certifier 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D6/55d 30. Name and address of perso who completed cause of death (Item 23a) (Type, Print) 8118 6000 ERFAN M.D LUCK KOAI) LANHAM, MD 20706 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 0 7 2006 Registrar

DHMH 17 Rev 1/2001

ORIGINAL

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death JULY 4 2006 Year **Physician** NATALIE BELL 8:47AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY GENERAL HOSPITAL OLNEY MONTGOMERY | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth | Months | Days | Hours | Min. | AUG | 24 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1916 1 M 2 KF 577 24 8013 89 Director MISSISSIPPI Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at MD. MONTGOMERY ROCKVILLE Yos 2 No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or Items 23a or 5572 BURNSIDE DR. #3 USA 20853 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 le marked other than "natural; or Item any injury or other traumatic event, the Medical Examina-Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2X No If Yes, Give Baltimore, Maryland 21215-0036 1 Yes 2 XNo Specify Specify: BLACK þ 3 ♥ Widowed 4 Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) CLERK FED. GOVT. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be NOT STATED NOT STATED 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5572 BURNSIDE DR. #3 Rockville, MD.20853 THEETA BELL/ Daughter 20b. Place of Disposition (Name of Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) MARYLAND NATU Place EM. 7/12/06 LAUREL, MD. 22. Name and Address of Facility WATSON F. H. 21. Signature Funeraf Service Licentee 3435 14th ST., N.W. WASH. DC. 20010 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician rneumonia 11 day /Medical Due to (or as a consequence of) **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physician and the burlal-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of). Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetaf dea 23b. Was decedent pregnant 23d. Date of delivery 2 Fetaf death 3 □Ectopic pregnancy in the past 12 months?
1 Yes 2 No
9 Unknown Day Year 4□Pregnant at time of death 5 Other (specify) P.O. detached 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, ξ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed 2 No 1 Tyes 1 🗌 Yes 2 No 25. Was case referred to medical 26. Place of Death | Check only one) Hospital: 1 Anpatient Other 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 🗙 No 2 ER/Outpatient 3 DOA this 27. Manner of Death Certification: 28b. Time of 28c. Injury at Work? Aftert 28d. Describe how injury occurred 1 Natural 2 Accident Injury 5 Pending death. 1 ☐ Yes 2 ☐ No investigation Director: the 3 🗌 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 🗌 Homicide within 24 hours after To the Funeral Dire Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) SHYAM PARKHIE M.D. 18101 PRINCE PHILLIP DRIVE OLNEY, MD. 20832 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar

## 06-05160

# Please Type or Print in Black Indelible Ink

Donald Ray B	augr	1	an - For State legistrar	St	ate of Ma	iryland		rtment of hificate of		id Ment	tal Hygiene	Reg. No	• 20	nr 1000
Physi Medical Exa		/	Donald								2. Date of I Month July 17	Day	Year	3. Time of Death 2304 hrs
Micalcal Exal			4a. Facility Name (if			ind number)		- I	4b. City, Town, or	Location o			4c. County of D	
			1501 Locust			12.4			Baltimore	. Lucio de	our lo pre	Diale (a.c.		District of Other
Funera Directo			5. Social Security N 220-72-03		6. Sex		e (In yrs. Ia:	st birthday) Yrs	Months Day				Fo	Birthplace (State or reign Maryland Country)
any		-	Jsual Residence of 10a. State	Decedent 10b. County	_		10c. City, 7	Town or Locat	tion					10d Inside City Limits
nd show s	و ان	_ N	Maryland	Balti	more		Hale	thorpe						1 Yes 2 X No
Maryla 28a-f	0 31 0	DIFECTOR	10e. Street and Nur	nber					10f. Zip Code	·		10g C	itizen of What (	Country?
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or items	Linest or mo	Laurer	11. Marital Status  1 Never Marrie  3 Widowed		arried Arm				es, specify Cuba	n, Mexican,	in? ( Specify Yes or Puerto Rican, etc.)	No-	White, et	nerican Indian, Black, c. White
urs afte	1	<u>a</u>  -	15. Decedent's Ed		or Dates:		npleted)	16a. Deceder	nt's Usual Occupa	tion (Give k		16b.	Specify: Kind of Busine	
Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show	eultai Ex	Completed	Elementary/Seco	• , ,	Colle	ege (1-4 or	5+)	during m	nost of working life er	e, DO NOT I	use retired)	Но	ome Impi	rovement
15-0036 filed within 7 Hygiene.			17. Father's Name (				•				s Name (First, Midd		n Surname)	
2121 ould be fi Mental I	To Do	-	Herman  19a. Informant's Na	Thern me/Relations	Baugh hip (Type, Prin			19b. Mailin	g Address (Stre		ah Gillar		City or Town, S	tate, Zip Code)
MD and 2 shoulth and n 27 is		-[	LuAnn Ba	ughman	/Wife			5653	Selford	Road	l, Haletho	rpe,	, Maryla	and 21227
or Heal	E II		20a. Method of Disp 1 XBurial 2		n 3 Remo	oval from St		lace of Disportematory or ot	sition (Name of ce ther place)	emetery,	Date	200	. Location - City	or Town, State
Baltimore, permit. Pages I ar Department of Hee Important: If ite	5	Ш	4 Donation 5	Other S	pecify:				s Cemete		7/21/2006	V t	ienna, 1	Maryland
Ball permit Depart Impor		1	21. Sign: r. f Fui	wo	& Ja	306	De	_ 78		eral treet	Home, P East Ne			
Physicia /Medic		1	23. Pirt I. Enter th failure. List onl		on each line						ardiac or respiratory	arrest, sl	hock, or heart	Approximate Interval Between Onset and
Examine			Immediate Cause (I or condition resultin			hadone or as a cons			and cocaine	e abuse				Death
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Vital ysiciar his cer	direction	e l	examiner?	2 No	Hospital:	Inpatie	ent 2 1	ER/Outpatien		Other <sub>4</sub>	Nursing Home 5	Resid	dence 6 🗸 O	ther Scene
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Divi To the Hospital or within 24 hours afte To the Funeral Dir		<u> </u>			miner: On the I	basis of exa					ce, and due to the courred at the time, d	ause(s) a		
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			30. Name and addr						Penn Street, I	Baltimore	e. MD 21201			
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Reg		ar		WI S	0 2006	Des	ne s	K A	MARIE					

			1 - For State Registrar	State of Ma	aryland / Dep		Health and	Mental Hygi	•	3 23339
	Physic /Med	ical	1. Decedent's Name (First, Middle, the Len Phil.	lips Brown				2. Date of Death Month July	8 2006	1751 M
,	Exami		4a. Facility Name (If not institution, g Peninsula Regio  5. Social Security Number  6.	nal Medica	l Center	SAL	or Location of Dea 15BURY r   If Under 24 Hrs		4c. County of Dea	mico
	Funeral Director		220–12–1163 Usual Residence of Decedent	1□ M 2 <b>5</b> 4 F	90 Yrs.	Months Days			<sup>9. Bi</sup> 1916 Ma	thplace (State or Foreign ountry) ryland
5	e Marylan ka-f ehow	ctor	MD 10b. County Dorche	ester	10c. City, Town or Lo	cation Cambri	dge			10d. Inside City Limits 1 ☐ Yes 2 No
3	3a or 28	i Dire	10e. Street and Number  106 Lee Drive			10f. Zip Code	21613	10	g. Citizen of What C	ountry?
)036 A	d within 72 hours after death with the Maryland Jiene. In then "natural", or flems 23a or 28a-1 ehow The Modical Examiner must be notified at	d by Funeral Director	11. Marital Status  1 ☐ Never Married 2 ☐ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent E Amed Forces? 1  Yes 2  If Yes, Give Year or Dates:	0	Was Decedent of If Yes, specify Cui	Hispanic Origin? (S ban, Mexican, Pue	Specify Yes or No- to Rican, etc.)	USA  14. Race - Am Black, Whi	
Maryland 21215-0036	S . c .	Completed	15. Decedent's (Specify only highest g	ducation rade completed) College (1-4or 5	(Give	dent's Usual Occu kind of work done DO NOT use retire	during most of wo	orking	6b. Kind of Business	/Industry
d 21	事業者		8 17. Father's Name (First, Middle, Las		*/	sales c		me (First, Middle, Ma	retail	
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	d 2 s th ar th ar t7 le trau		19a. Informant's Name/Relationship Richard L. Brown					ural Route Number, ( Cambridge		
Baltimore,	e = 5 e		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ↓ 4 ☐ Donation 5 ☐ Other (Spec		20b. Place of Dispo	sition (Name of natory or other pla	ice)	Date 20	Dc. Location - City or Hurlock, M	Town, State
Balti	permit. Pa Departmen Important: eny injury once.		21. Signature of Funeral Service Lice		22	. Name and Addr	ess of Facility T	homas Fundambridge,	eral Home	P.A.
1	Physician /Medical Examiner		23a. Part1. Enter the disease, or cor shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a	the death. Do not ent e. YPOXIA consequence of):	er the mode of dy	ing, such as cardia	c or respiratory arres	t,	Approximate Interval Between Onset and Death
	te be executed ysicien and ne burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter underlying Cause (Disease or injury that initiated events resulting in death) Last	с.	consequence of):					
. Box	res that the death certifica igned by the attending ph be detached for use as th	by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 IDNo 9 ☐ Unknown	23c. If yes, outcome o 1 □ Live birth 2 4 □ Pregnant at t 9 □ Unknown	! ☐ Fetal death 3 ☐	Ectopic pregnanc Other (specify)	у		23d. Date of dei Month	ivery Day Year
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Z Z	/sicien s certifi director	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☑ No	Hospital: 1 Inpatient	t 2 ER/Outpatient	SE DOL OU		th (Check only one)		
ion of	ding After fune	<b> -</b>	27. Manner of Death  1 Matural 5 Pending 2 Accident Investigatio	28a. Date of Injury (Month, Day	28b. Time of	28c. Injui	4 🗆 Nursing n	ome 5 Residence 28d. Describe how		sify)
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	To the within 2 To the complet		29b. Signature and title of certifier	luri	MD	29c. Licens	e number 2060515	29d.	Date signed (Month	, Day, Year)
			30. Name and address of person who		eth (Item 23a) (Type, F Easterns		. SAUS	BURY M	D 21804	
	Sta Registr		31. Date filed (Month, Day, Year)	2006 32. Registrar		Courtes				

06-05094 Bonnie Betts

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2006 23340

		1- For State Registrar	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	Certif	icate of	Death		R	eg. No.		0 2004
Physicia	an/	1. Decedent's Name (First, Middle,	•				-	2. Date of Dea	th Day	Year	3. Time of Death
Medical Exami	ner	Bonnie Adams				. Ch. Taur and	andian of Day	July 16, 2	006		0730 hrs
		<ul><li>4a. Facility Name (if not institution,</li><li>121 Eastern Avenue</li></ul>	give street and number)		41	o. City, Town, or L Salisbury	ocation of Dea	atn		. County of Death Vicomico	
Funeral		Social Security Number 6.	. Sex 7. Age	e (In yrs. last l	birthday)	If Under 1 Year	If Under 24H	Hrs. 8. Date of Bir	th(MM/	DD/YYYY) 9 Bir	
Director		216-70-6785	1 M 2XF	45	Yrs.	Months Days	Hours N	<sup>/lin.</sup> 8–10–1	960	Foreig Co	n untry) MD
Ś.		Usual Residence of Decedent  10a. State 10b. County		10a City Tay	wn or Locatio			<b>'</b>			10d Inside City Limits
Maryland 28a-f show any d at once.		MD Wicon	nico			11					1 Yes 2 X No
uylanc 8a-f sh	Director	10e. Street and Number	iiico	581.	isbury	10f. Zip Code		1	0a Citiz	zen of What Cour	
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland the and Mental Hygiene. n 27 is marked other than "natural", or items 23a or 28a-f shoumatic event, the Medical Examiner must be notified at once.	Dire	121 Eastern Ave	enue		ĺ	21804			U.	S.A.	
h with ms 23.	eral	11. Marital Status	12. Was Decedent Armed Forces?	Ever in U.S.		Decedent of Hisp s, specify Cuban,		Specify Yes or No		14 Race - Ameri	can Indian, Black,
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5-0036 led within 72 Hygiene. other than '	mpl		4	I	Regist	ered Nur				sisted I	Living
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21215-0036 and be filed within 72 Mental Hygiene. marked other than 'e event, the Medical	To Be	Unknown 19a. Informant's Name/Relationship	(Type, Print)		19b. Mailing			ce Pusey	nber Cit	ty or Town State	Zin Code)
MD and 2 should be and 27 is aumatic		Brenda J. Eshan	n (Sister)	- 2	404 A						21804
		20a. Method of Disposition  1 Burial 2 X Cremation	2 Removed from Str	cren	natory or othe	ion (Name of ceme	•	Date		ocation - City or	
Baltimore, permit Pages I ar Department of Hee Important: If ite		4 Donation 5 Other Spec		Crem	atory	of Delma	rva 07,	/21/06	De	elmar, D	elaware
Baltimo permit Page Department of Important: injury or oth	Ì	21. Signature Funeral Service Lie	censee			me and Address o		me			
		23a. Part I. Enter the disease, or co	omplications that aused	the death Do	13	E. Grov	e Stre	et Delm	ar,	DE 199	40 Approximate Interval
Physician /Medical	, ,	failure. List only one cause of	reach line. a Methadone :					o or roopii alory airi	301, 0110	ok, or ricart	Between Onset and Death
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Box 687  re death certific  re attending ped for use as t	Physiciar	1 Yes 2 No 9 V Unkno			5 Othe	er (Specify)					
<b>~</b> = ₹ 5 2	by Pt	Part II. Other significant condition	s contributing to death	but not resul	Iting in the un	derlying cause giv	en in Part I.				he cause of death?
S, P.C uires that n signed l	ed b							1 Yes			ably 4 🗸 Unknown
cords law requi	Completed							24a. Was a autop perfor	sy		opsy findings available ompletion of cause of
tal Rec cian: The l certificate b ector, page	5							1 Yes			s 2 No
ital Fician:	Be	25. Was case referred to medical examiner?	Hospital:	nt 2 🗸 ER	VO. to ations		f Death (Chec				
of Vision of Vision of Physical After this funeral dir	£	1 Yes 2 No 27. Manner of Death	28a. Date of Injur	ry 28	b Time of Inj			sing Home 5	Resider		
Division of Vital Records, tal or Attending Physician: The Law requirers after death al Director: After this certificate has been sited in by the funeral director, page 2 should the funeral director, page 2 should the funeral director.	Certification:	1 Natural 5 Pending			Ind 7:00	4 7 7-	s 2XX No	unk	,	,	
Visi or Att fter de Directe	ifica	2 Accident Investig 3 Suicide 6 Could r	28e Place of Ini			factory, office bui		28f. Location (S	Street an	nd Number or Rur	al Route Number, City
Divis spital or At tours after d neral Direc filled in by	Ser	4 Homicide	ined (Specify)	House				Baltimor	e. M	21 Eastern	ave.
Division To the Hospital or Attendit within 24 hours after death To the Funeral Director: /	Medical		sician: To the best of my ner:On the basis of exan and manner stated.								
F 3 F 3	Me	29b. Signature and title of certifier				29c. License			29d D	ate signed (Mon	th, Day, Year)
		will	_			O.C.M	.E.		July	17, 2006	
		30. Name and address of person will Ana Rubio MD. Assis	ho completed cause of de tant Medical Exam			reet, Baltimor	e, MD 212	01			
St	ate	31. Date filed (Month, Day, Year)	32. Régistrar		2		_,=				
Regist		JUL 2 0	2006 Mage	an H.	Bra	Par 1					

			1 - State of Maryla		rtment of Hea				23341
			Registrar  1. Decedent's Name (First, Middle, Last)	0011	incate of De		Reg. No. 1 Date of Death	10.	3. Time of Death
1	Physici		RAYMOND BENDER			-	Month E	Day Year	08-33AM
Jà.	/Medic Examin		4a. Facility Name (If not institution, give street and number)		4b. City, Town, or Loc	cation of Death		4c. County of Death	10 % 33A
	LXdiiii	e (°	CIVISTA MEDICAL CENTER	2	LA Pr	AT A		HARLS	
	Funeral		5. Social Security Number 6. Sex 7. Age (In y	rs. last birthday)		Under 24 Hrs. 8.	Date of Birth (Month, Day, Yea	9. Birthp	place (State or Foreign
L	Director		579-22-7968 <sup>1</sup> X <sup>M 2□F</sup> 8	O Yrs.	Monais Bays	Octol			nío
	and		Usual Residence of Decedent  10a, State 10b, County 10c.	City, Town or Loc	cation			1	Od. Inside City Limits
	daryl f sho	ō	MD St. Mary's	Charlot	te Hall				1 ☐ Yes 2X No
	28a-	Director	10e. Street and Number		10f. Zip Code		10g. 0	Citizen of What Cour	ntry?
	35 ol	D	29449 Charlotte Hall Ro	ad	206	22		USA	
	deat ems	Funeral	11. Marital Status 12. Was Decedent Ever in Armed Forces?		Vas Decedent of Hispa Yes, specify Cuban, N		Yes or No-	14. Race - Americ Black, White,	
9	or ite	F.	1 ☐ Never Married 2 ☐ Married 1 ☐ Ves. Give			Specify:	111, 010.7	Specify: Wh:	
	filed within 72 hours after death with the Maryland Hygiene. Uther then "natural", or items 23e or 28e-f show ant, the Medical Examinar must be routiled at	d by	3X Widowed 4 Divorced Year or Dates:				1 . 5		
7	n 72	Completed	15. Decedent's Education (Specify only highest grade completed)	16a. Decedo (Give k	ent's Usual Occupation kind of work done durir OO NOT use retired)	n ng most of working	16b.	Kind of Business/Inc	dustry
7	withi iene. then	mo	Elementary/Secondary (0-12) College (1-4or 5+)		ngineer		м	Multi Tra	ade
b	filed Hyg other	Be C	17. Father's Name (First, Middle, Last)			. Mother's Name (Fi			440
<u>a</u>	ould be filed within Mental Hygiene.  wrked other then satic event, the Manage of the Mental Manage of the Mental	To B	Frank A. Bender		1	Maude L.	Stone		
Maryland 21215-0036	and and		19a. Informant's Name/Relationship (Type, Print)		g Address (Street and				
	1 and 2 Health em 27 i		James F. Bender/Son		Derby C				
timore,	Pages 1 nent of He int: If iter iry or oth		1 Burial 2 TkCremation 3 Removal from State		atory or other place)	Date		Location - City or To	
Ē	permit. Pages Department of Important: If it any injury or once.		116.5	ALE	eld-Echol		-	rlotte I	
Bai	permit. Departr Imports any inju		21. Signature of Funeral Service Licensee . M00	943	Name and Address of REHART – E	CHOLS FU	JNERAL	HOME, P.A	Α.
			23a. Part1. Enter the disease, or complications that caused the di	eath. Do not ente	211 ST Mer the mode of dying, s	ARY'S AV	/E LA	PLATA, M	Approximate
b			shock, or heart failure. List only one cause on each line. Immediate Cause (Final	0.47			STATE OF THE STATE	O.	Interval Between Onset and Death
	P <del>nysician</del> /Medical·		disease or condition resulting in death)  a  Due to (or as a cons	sequence of):	Colcon	A24 19	Mapy	U/3/352	
Б	Examiner		PTASOO	SCLER	THE CH	LO LOU OSC	1400 01	55455	
9.5	P ==	ner	if any, leading to immediate cause. Enter Underlying				4-1-1-1		
	and trans	Examin	Cause (Disease or injury that initiated events c.						
8760,	cate be executed physician and the burial-transit	al E	resulting in death) Last Due to (or as a cons	sequence or):					
	cate chy: the	dical	d						
Box 6	The law requires that the death certificate has been signed by the attending I agge 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pre					23d. Date of delive	arv.
ă	death s atte	ciai	in the past 12 months?		Ectopic pregnancy Other (specify)			Month	Day Year
0	t the c by the	hys	9 ☐ Unknown						
	gned gned	by P	Part II. Other significant conditions contributing to death but not	resulting in the un-	derlying cause given in	n Part I.	23e. Did tobacco	use contribute to th	ne cause of death?
Records,	equire en siç ould t	ted	END STACE RENAL!	DISCASS	E DIABRE	725	1 🗌 Yes	2 No 3 Prob	ably 4 Unknown
ecc	law ra as be 2 sh	ple	MELLITUS, DEMEN	VTA			24a. Was an autopsy	prior to con	psy findings available moletion of cause of
	The sate h page	Completed	/				performed? 1 ☐ Yes 2 ☑ N	death? No 1 ☐ Yes	2 □ No
Vital	Attending Phyaician: The law ir death. ector: After this certificate has bettire the funeral director, page 2 s	Be	25. Was case referred to medical examiner?  Hospital:			B. Place of Death (C)	neck only one)		
of	Phyai this al dir	10	1 ☐ Yes 2 ☐ No ☐ Splital. 1 ☐ Inpatient 2  27. Manner of Death 28a. Date of Injury	2 DER/Outpatient 28b. Time of	28c. Injury at		5 Residence	6 ☐Other (Specify	y)
UQ	ding Phys h. After this funeral di	tion	1 ☑Natural 5 ☐ Pending (Month, Day Year		Work?	2 No	Describe flow inj	dry occurred	
Division of	l or Attendi after death Director: A	fica	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - A	At home, farm, stre		28f.	Location (Street a	and Number or Rura	l Route Number.
Š	after after Dire	Certification:	4 Homicide determined building, etc. (Spe	ecify)	•		City or Town, Sta	te)	
	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page		29a. Certifier  1 Certifying Physician: To the best of my    Check only   2 Medical Examiner: On the basis of exam	knowledge, death	occurred at the time, o	date and place, and	due to the cause(	s) and manner as si	ated.
	the H iin 24 the Fi	ledical	one) and manner stated.	mation and/or invi					
	To with To I	Σ	29b. Signature and title of certifier		29c. License nu	imber	29d. D	ate signed (Month, I	Day, Year)
ļ .			Na UN NAZHII			56752	0	1/07/2	006.
1	BIT		30. Name and address of person who completed cause of death (I		Print)		1m:	1 2	1
4	Sta	te	31. Date filed (Month, Day, Year) 32. Sigistrar's Sig	C Ro AD	CHARL	STIE	MLL	(45) 20	622
	Registr	_	1111 1 1 2006 Bleeve		BALL				

		ı	For State Registrar	State	of Maryla	•	artment of rtificate o				giene Reg. No.	2006	23342
			1. Decedent's Name (First, Middle	, Last)						2. Date of Dea Month		Vaar	3. Time of Death
	Physici: /Medic		Jean V. Cr	isp						July	6 <b>.</b>	2006	4:45p M
	Examin		4a. Fecility Name (If not institution	, give street and n	iumber)		4b. City, Towr	n, or Location	on of Death		4c. (	County of Death	
			535 Lakelan	d Road	South		S	everr	na Pa	rk		Anne Ai	cundel
	Funeral	0	5. Social Security Number	6. Sex		s. last birthday	If Under 1 Ye Months Da		ler 24 Hrs. s Min.	8. Date of Birth (Month, Day	h Year)	9. Birthp	place (State or Foreign
	Director		216-16-4723	1 □ M 2 <b>½</b> F	80	6 Yrs.	World 5	ys Hour	3 141111.	Jan. 1			MD
	D		Usuat Residence of Decedent  10a. State 10b. County		100 (	City, Town or L							04 1-24 05 12 5
	aryla ehov	_		arundel	i i	JILY, TOWN OF L		erna	Dark			1	0d. Inside City Limits 1 ☐ Yes 2 🔀 No
	88 -f	ct		: Atuidet					Palk				
:	or 2	Director	10e. Street and Number	- 2 -			10f. Zip Cod				10g. Citiz	en of What Cour	,
,	be lied within 72 hours after death with the Maryland tal Hygiane. It have then then "naturel", or iteme 23s or 28s-f show event, the Madical Examinar must be notified at		535 Lakeland					21146				US	
	er de	Funeral	11. Marital Status	Armed F		U.S. 13.	Was Decedent of If Yes, specify C	of Hispanic ( Juban, Mexic	Origin? (Spe can, Puerto	ecify Yes or No- Rican, etc.)	1	<ol> <li>Race - Americ Black, White,</li> </ol>	
9	or i	by F	1 ☐ Never Married 2 ☑ Marr 3 ☐ Widowed 4 ☐ Divorced	If Yes, G	2 MNo Sive		1 ☐ Yes 2 🔀 1	No Speci	ify:			Specify:Whit	e
9500-61212	hours after turei', or its el Examine			Year or	Dates:	100 0000	death Head Or						
ဂ်	within 72 ane. than "nat he Medici	Completed	15. Decedent (Specify only highes	it grade completed	1)	(Give	ident's Usual Oc i kind of work do DO NOT use rei	ne during m	ost of worki	ing	16b. Kin	d of Business/Ind	dustry
7	with ane.	Ē	Elementary/Secondary (0-12)	Cotlege	(1-4or 5+) 4	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		maker				Home	
<b>D</b>	e filed within al Hygiane. I other than " vent, the Me	ပိ	17. Father's Name (First, Middle,	Last)	4	1	1101110			(First, Middle,	Maiden S		
and	Aental Aental rked o tic eve	00	Otto Hofman	,						a Ennis		, , ,	
<b>5</b>	nark mark	ဥ	19a. Informant's Name/Relationsl	nin (Type Print)		19h Mail	ing Address /Stre				r City or	Town, State, Zip	Codel
200	d 2 s th an th an trau		William Crisp									na Park,	71
ญ์	Heal Heal ther		20a. Method of Disposition	Husbaria	20b.	. Place of Disp	osition (Name of			Date Date		ation - City or To	
	ages nt of r or o		1 X Burial 2 ☐ Cremation		n State	cemetery, cre	matory or other p	olace)	Jul	y 10,			
֓֞֞֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓֓	rtme rtant njury		4 Donation 5 Other (S) 21. Signature of Furieral Service							006		oklyn Pa	
Balt	permit. Pages 1 and 2 should be I Department of Health and Mental i Important: if item 27 is marked or any injury or other traumatic eve poce.		11 Nemry	5ALL	er		Barranco 495 Gov.	% So Ritc	ns, P hie H	.A. Seve	erna erna	Park Fu Park, M	neral Home D 21146
			23a. Part1. Enter the disease, or shock, or heart faiture. List	complications that	t caused the de								Approximate Interval Between
	hysician		Immediate Cause (Final	only one cause on	2010	10 01 10	(A					2	Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to	o (or as a conse	NOW							54540
ŀ	Examiner												
		ē	Sequentiatly list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to	o (or as a conse	equence of):							
	uted d ansit	Examiner	Cause (Disease or injury that initiated events	<b>S</b>									
<b>5</b>	exec an an rial-tr	Exa	resulting in death) Last	Due to	o (or as a conse	equence of):							
04/8	death certificate be executed e ettending physician and id for use as the burial-transit	dical		d									
9	inca g ph as th	(a)		1333		·							
Z OZ	andin use	Physician/M	IF FEMALE: 23b. Was decedent pregnant		utcome of preg		75-4				23	3d. Date of delive	ry
ָ מ	d for	Cla	in the past 12 months?	4□Preg	birth 2 □Fe gnant at time of		⊒Ectopic pregna ⊒ Other (specify)					Month	Day Year
Ο,	by the	hys	9 ☐ Unknown	9□ Unk	nown								
, .	w requires thet the de been signed by the should be deteched	by P	Part II. Other significant condition	ns contributing to	death but not re	esulting in the u	inderlying cause	given in Pai	rt I.	23e. Did to	bacco us	e contribute to th	e cause of death?
cords,	quire on sig uld b									1 🗆 Y	es 2	No 3□Prob	ably 4 Unknown
Ü	as bee	Completed								24a. Was a	ın	24b. Were auto	psy findings available
E :	sician: The faw s certificete has b lirector, page 2 s	E C								autops	nued?	prior to cor death?	npletion of cause of
	ifficet or, p	Ö	25. Was case referred to medical					26 Pla	non of Dooth	1 ☐ Yes ✓		1 🗆 Yes	2   No
<b>&gt;</b> :	Physician: rthis certific ral director,	0 B	examiner?	Hospital:	Inpatient 2	☐ ER/Outpatie	nt 3 DOA	Other		1		Other (Specify	al.
ō ;	ar this	<b>-</b>	27. Manper of Death	28a. Date	e of Injury	28b. Time o		njury at Vork?		28d. Describe h			"
DIVISION	th.	ig i	Natural 5 Pending	9	onth, Day Year)	Injury		Vork? ∐Yes 2∣	□No				
2	dea ctor	flca	3 ☐ Suicide 6 ☐ Could r	not be 28e. Place	ce of Injury - At	home, farm, st	reet, factory, offic	ce		28f. Location (S	treet and	Number or Rura	l Route Number.
<b>5</b> .	after Dire	Certification:	4 Homicide	buil	ding, etc. (Spec	cify)				City or Town	n, State)		
	spite nours nera / fille		29a. Certifier Certifyin	g Physician: To th	ne best of my kr	nowledge, deal	h occurred at the	time, date	and place, a	and due to the c	ause(s) a	and manner as st	ated.
:	P Ho	Medical	(Check only 2 Medical I	Examiner: On the	basis of examination	nation and/or in	ivestigation, in m	y opinion, d	leath occurre	ed at the time, d	late and p	place, and due to	the cause(s)
1	To the Nespital of Attending Physician: To the Funeral Director: After this certific completely filled in by the funeral director.	ž	29b. Signature and title of certifier			2		ense numbe			9d. Date	signed (Month, I	Day, Year)
			) feem	nen	- my	)	D	522	330		Jul	47,7	2006
			30. Name and address of person	who completed car	use of death (Ite	em 23a) (Type,	Print)		. 1			1 11	
				Nevny	- 9a	se.	Print) 8+gate	Ro	1#3	D, Au	inay	polis, n	10 7148/
	Sta	te	31. Date filed (Month, Day, Year)		Registrar's Sign	nature				/		,	J. J. V
	Registr	_	nn 1 0	2006		K A	and a						

			4 101	epartment of Health and I Certificate of Death	Mental Hygier	Z 11 11 b / 3 5 4 3
	Physici /Medi		1. Decedent's Name (First, Middle, Last)  CUENCIENT		2. Date of Death	3. Time of Death 6:20 A M
	Examir		4a. Facility Name (If not institution, give street and number)  DOCTORS HOSPITAL	4b. City, Town, or Location of Death	h 4	PRINCE GEORGE'S
	Funeral Director		255-38-0801	nday) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	(Month, Day, Yea	9. Birthplace (State or Foreign Country) GEORGIA
	Maryland I-f show	or	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town           MD         PRINCE GEORGE SUPPER	or Location MARL BORO		10d. Inside City Limits 1X☐ Yes 2 ☐ No
64	death with the I	Direct	10e. Street and Number	10f. Zip Code 20774		Citizen of What Country?
2 × ×	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiens 1.  Department of Health and Mental Hygiens 1.  Till filem 23 a or 28s-f show eny injury or other treumatic event, the Medical Examinar must be notified at ance.	Funeral Director	2011 HANCOCK DRIVE  11. Marital Status  1 Never Married 2 Marned  1 Yes, Gree	13. Was Decedent of Hispanic Origin? (Silf Yes, specify Cuban, Mexican, Puerton 1  Yes 2  No Specify:		14. Race - American Indian, Black, White, etc.
7.E.R.	72 hours after naturel; or ite	leted by	3 LS Wildowed 4 Divorced Year or Dates:  15. Decedent's Education 16a. I	Decedent's Usual Occupation (Give kind of work done during most of work life. DO NOT use retired)	rking 16b.	Specify: BLACK Kind of Business/Industry
0 22	filed within Hygiene. other than	Completed	12th College (1-4or 5+)	DAY CARE PROVIDER	PR	IVATE
7 5 Vand	should be fill of Mental H marked ott	To Be	17. Father's Name (First, Middle, Last) VIRGIL NEWBERRY	18. Mother's Nan MAM	ne (First, Middle, Maide IE BROWN	n Sumame)
Na.	and 2 sh salth and n 27 ie m er treum		· · · · · · · · · · · · · · · · · · ·	Mailing Address <i>(Street and Number or Ru</i> 11 HANCOCK DRIVE UPI		
EH Baltimore	Pages 1 nent of He int: If iter		1 A Burial 2 Cremation 3 D Removal from State cemetery	Disposition (Name of , crematory or other place) SVILLE BAPT. CEME. 7		Location - City or Town, State
Balti	permit. Departrimporte eny inju		21. Signature of Funeral Service Licensee	22. Name and Address of Facility J 7474 LANDOVER RD	. B. JENKI	NS FUNERAL HOME
8760	Physician: The law requires that the death certificate be executed with the certificate be executed with the sertificate has been signed by the attending physician and majority and director, page 2 should be detached for use as the burial-transit at page 2.	dical Examiner	resulting in death)  Due to (or as a consequence of AR DID MARK)  Seque.tially list conditions, if any, leading to immediate  Due to (or as a consequence of Due to (or as a consequence o	DAC FRAILURE		Approximate Interval Between Onset and Death
P.O. Box 68760	the death certifical y the attending phy ched for use as th	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown 23c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown	3 Ectopic pregnancy 5 Other (specify)		23d. Date of delivery  Month Day Year
	w requires that the deben signed by the should be detached	þ	Part II. Other significant conditions contributing to death but not resulting in the HYPOCTED SICO	the underlying cause given in Part I.		use contribute to the cause of death?
of Vital Becords.	The law requested the second second the second seco	Completed			24a. Was an autopsy performed?	24b. Were autopsy findings available prior to completion of cause of death?  1 □ Yes 2 ≅ No
Vita	sician: Th certificate rector, pag	o Be	25. Was case referred to medical examiner?  Hospital:	0.00	th (Check only one)	
Ď	ding Physician: The	1-	27. Manner of Death 28a. Date of Indiany 28b. Til	Datient 3 DOA 4 Nuising H	ome 5 Residence	
Division	To the Hospitel or Attending within 24 hours alter deading to the Furnerel Director: Alter completely filled in by the fune	Certification:	1 Natural 5 Pending 2 Accident investigation 3 Suicide 4 Homicide 6 Could not be determined 28e. Place of Injury - At home, farr building, etc. (Specify)	M 1 Tes 2 No	28f. Location (Street a	and Number or Rural Route Number, te)
	To the Hospitel or Attendi within 24 hours after death To the Funerel Director: A completely filled in by the fo	Medical Ce	29a. Certifier (Check only one)  1 Certifying Physician: To the best of my knowledge and manner stated.	death conjuried at the time data and plane for investigation, in my opinion, death occur	and due to the cause( rred at the time, date ar	e) and manner as stated nd place, and due to the cause(s)
	To the within 2	Med	29b. Signature and title of certifier	29c. License number	G 29d. D	ate signed (Month, Day, Year)
	CO CO		30. Name am address of person who completed cause of death (Item 23a) (T	ype, Print)  St S / ANDONE PI	) (11.4)	CALY MA 20-765
	Sta Registi		31. Date filed (Month, Day, Year)  32. Registrar's Signature		City	1010 20.55

l.		For 1_ State		epartment of Health and I Certificate of Death		2006	23314
		Registrar  1. Decedent's Name (First, Middle, Last		Detilicate of Death	2. Date of Death	J. No.C. U U U	3. Time of Death
Physici		Bever1v	Cox		Month	Day Yeer 2006	8:32 P <sup>M</sup>
/Medic Examin		4a. Fecility Name (If not institution, give		4b. City, Town, or Location of Deat		4c. County of Death	0.52 1
LXamii		Waldorf Healthcare	Center	Waldorf		Charles	
Funeral		5. Social Security Number 6. Se	x 7. Age (In yrs. last birth		(Month, Day, )	(ear) 9. Birthp	olece (State or Foreign
Director		220-12-3915	M 2 <sup>XS</sup> F 78 Y	s. Notice Bays	10/06/1	927 Wash	ington, DC
and		Usuel Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location			0d. Inside City Limits
Maryl.	ō	Maryland Charles		sv <b>i</b> lle			1 Yes 2 No
death with the Maryland me 23a or 28a-f ehow court be notified at	Director	10e. Street and Number	1	10f. Zip Code	100	g. Citizen of What Cour	ntry?
h with		7301 Leonardtown	Road	20637		U.S.A.	
	Funeral	11. Marital Status	12. Was Decedent Ever in U.S. Armed Forces?	13. Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puerl	pecify Yes or No-	14. Race - Americ Black, White,	
or Its		1 Never Married 2 Married	1 ☐ Yes 2 ☐ No If Yes, Give	1 ☐ Yes 2 XNo Specify:		Specify: Whi	
I Z I 3-UU30 within 72 hours after death with the Marylan ane. then "ratural", or iteme 23e or 28e-f ehow then Marical Examinational be notified at	d by	3 XWidowed 4 Divorced	Year or Dates:				
in 72 in mail	Completed	15. Decedent's Edu (Specify only highest grad	e completed) (	Decedent's Usual Occupation Give kind of work done during most of wor life. DO NOT use retired)	rking	6b. Kind of Business/In	dustry
withir then the Man	E O	Elementary/Secondary (0-12)	College (1-4or 5+)	Accountant		Private	
be filed withintal Hygiene. Ital Hygiene. Ind other then	0	17. Father's Name (First, Middle, Last)			me (First, Middle, Ma	aiden Sumame)	
IZENCE IN MINISTRATE IN MINIST	To B	Lyle Rice		Sara	h Gale		
Marylan d 2 should be th and Mental 7 is marked of treumatic ev	j j	19a. Informant's Name/Relationship (7)	rpe, Print) 19b. I	Mailing Address (Street and Number or Ru	ıral Route Number, (	City or Town, State, Zip	Code)
2 5 = 2 E	1	Donna Cave-Daught		l Leonardtown Rd. H			
0 0		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ F	cemetery,	Disposition (Name of crematory or other place)		c. Location - City or To	
EIIM Pag tment tant: I		4 ☐ Donation 5 ☐ Other (Specify)		ncoln Cemetery 07/0			4D
BAILIMOR permit. Pages Depertment of Important: If it eny injury or o		21. Signature of Funeral Service Licens	3//	22. Name and Address of Facility Fo			700
	20. 3	23a Party Enter the disease or comp	ications that caused the death. Do no	3401 Bladensburg r			Approximate
1.		snock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.	1 1	LOWN	1	Interval Between Onset and Death
Pnysician /Medical		disease or condition resulting in death)	Due to (or as a consequence of		Y CON ON	1100/172E	DSEXHON
Examiner			Due to (or as a consequence of	<i>j.</i>			J
THE RESIDENCE	Jer	if any, leading to immediate	b.  Due to (or as a consequence of	):			
cuted nd ransit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	c				
60, be executed icien and burial-transit	EX	resulting in death) Last	Due to (or as a consequence of	):			
cate be executed physicien and sthe burial-transit	dical		d				
i o a	/Me	IF FEMALE:	23c. If yes, outcome of pregnancy				***
BOX eath cer attendir for use	Physician/Me	in the past 12 months?	1 Live birth 2 Fetal death	3 ☐ Ectopic pregnancy 5 ☐ Other (specify)		23d. Date of delive Month	ery Day Year
the d	ysle	1 ☐ Yes 2 █ No 9 ☐ Unknown	9 Unknown	onioi (speeny)			
that the detail	by Pl	Part II. Dther significant conditions co	ntributing to death but not resulting in t	he underlying cause given in Part I.	23e. Did toba	cco use contribute to the	ne cause of death?
COLDS  * requires been sign should be			<del></del>		1 Xves	2 No 3 Prob	ably 4 Unknown
eco lawre es bec	Completed				24a. Was an	24b. Were auto	psy findings available mpletion of cause of
The The ste he page	EO				autopsy performe	death?	
VICAL MEC sician: The law certificete hes t lirector, page 2 s	Be	25. Was case referred to medical examiner?			ath (Check only one)		
	은	1 ☐ Yes 2 ZNo	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outp			ce 6 □Other (Specif	v)
After Funera	lon:	27. Manner of Death 1 ☑Natural 5 ☐ Pending	28a. Date of Injury 28b. Tir (Month, Day Year) Inj		28d. Describe how	injury occurred	
DIVISION OF I or Attending Phy after death. Director: After thi d in by the funeral of	lcat	2 Accident investigation 3 Suicide 6 Could not be	28e. Place of Injury - Al home, farm		28f. Location (Stre	et and Number or Rura	I Route Number
after Dire	Certification:	4 Homicide determined	building, etc. (Specify)	in stroot, factory, office	City or Town,	State)	, riodio rambo,
spite hours nerei		29a. Certifier TacCertifying Phy	sician: To the best of my knowledge,	death occurred at the time, date and place	, and due to the cau	se(s) and manner as s	ated.
UNUSION To the Hospitel or Attending within 24 hours after death. To the Funerel Director After completely filled in by the fune	Medical	(Check only 2 Medical Exami	ner: On the basis of examination and and manner stated.	or investigation, in my opinion, death occu	irred at the time, date	e and place, and due to	the cause(s)
To t To t com	Σ	29b. Signature and title of certifier	1 1)(1)	29c. License number	290	d. Date signed (Month,	Day, Year)
(6)		Jun XI F	The Man	N) D5015	7	1131	90
Je		30 Name and address of person who co	ompleted cause of death (Item 23a) (T	ype, Print) 1 11345 Kenyszerver (	11/10	DADE A	ry 50603
Sta	to	31. Date filed (Month, Day, Year)	32. Registrar's Signature	1 PASSIMAL CACIL	4. MAT	101010 (N	MX 50 603
Sta Registr		JUL 0 7 2006	en & April	•			

			1 - For State Registrar	State of Marylar		artment of H rtificate of L		Mental Hy	rgiene Reg. No. 2	06	23345
	Physici		1. Decedent's Name (First, Middle, Last Esther P. Cohen	)				2. Date of De Month	Day	Year	3. Time of Death
7	/Medio Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	July	4c. County	of Death	0740
	Zami		Suburban Hospital			Bethesd	а		Mont	gome	ry
	Funeral Director		5. Social Security Number 6. Se		last birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bil (Month, Da	1	9. Birthp	place (State or Foreign
			Usual Residence of Decedent					1200. 1	J, 1713		
	urylar how	_	10a. State 10b. County	10c. Ci	ity, Town or Lo	cation				1	Od. Inside City Limits
	8e-f	octo	MD Montgomer	у Ве	thesda						1½ Yes 2 □ No
	vith th	Dire	10e, Street and Number			10f. Zip Code			10g. Citizen of W	/hat Cour	ntry?
	23e	rai	10250 Westlake Dr			20817			U.S.A.		
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Maryland Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other than "natural", or Iteme 23e or 28e-f show among injury or other traumatic event, I'm Medical Examinant must be invitted a once.	Completed by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 ☒ Widowed 4 □ Divorced	12. Was Decedent Ever in L Armed Forces? 1 ☐ Yes 2 ☒ No If Yes, Give Year or Dates:		Was Decedent of Hi f Yes, specify Cuba I ☐ Yes 2\$\textit{\textit{Z}} No	ispanic Origin? (Sp n, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		k, White,	
Ŏ	2 ho	ted	15. Decedent's Edu		16a. Deced	ient's Usual Occupa	ation		16b. Kind of Bu		
215	hin 7 B. "n Med	ple	(Specify only highest grad Elementary/Secondary (0-12)	e completed) College (1-4or 5+)	life.	kind of work done of DO NOT use retired,	furing most of work )	king			,
2	od wit	Corr	12		Can	cpet Ret	ailer		Retai	1	
힏	al Hy al Hy d oth	Be (	17. Father's Name (First, Middle, Last)				18. Mother's Nam	e (First, Middle	, Maiden Sumam	a)	
<u>X</u>	Ment Ment arke	10	Louis Pollock				Annie				
, Maryland	and 2 should be and and 27 is m		19a. Informant's Name/Relationship (T) Susan Mischel – n			Alcott S					Code)
Baltimore,	Pages 1 and of He har if item ry or oth		20a. Method of Disposition  1X Burial 2 □ Cremation 3 X 4 □ Donation 5 □ NOther (Specify)	Removal from State	cemetery, cren	sition (Name of natory or other place of Memoria	9)	Date ·06	20c. Location -		
Balti	permit. Departm Importa any inju		21. Signature of Funeral Service Licens	· ·	22	Name and Addres	s of Facility Edw	ard Sag	el Funer	al D	irection
			23a. Part1. Enter the disease o compl	ications that caused the deat					-	2005	Approximate
	Physician /Medical		shock, or heart failure. Ust only of Immediate Cause (Final disease or condition resulting in death)	Acute Myoca  Due to (or as a consec	ard <b>i</b> al						Interval Between Onset and Death
	Examiner		Sequentially list conditions,	Coronary Ar		isease					
	sit ad	ine	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseq	quence of):						
	and I-tran	Examiner	that initiated events resulting in death) Last	Due to (or as a conseq	Tuence of):						
68760,	ificate be executed g physicien and as the burial-transit	edicai E	L.	d	(301100 SI).						
_	ertifica ding ph		IF FEMALE:	0- 1							
P.O. Box	The law requires that the death certif sie has been signed by the attending bege 2 should be detached for use a	Physician/M	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☑ No 9 ☐ Unknown	3c. If yes, outcome of pregna 1 ☐ Live birth 2 ☐ Feta 4 ☐ Pregnant at time of d 9 ☐ Unknown	al death 3	Ectopic pregnancy Other (specify)			23d. Date Mon		Day Year
	that ned by deta	by Pr	Part II. Other significant conditions con	ntributing to death but not res	ulting in the ur	iderlying cause give	n in Part I.	23e. Did t	obacco use contri	bute to th	e cause of death?
rds	quires t		Pneumonia, Renal F	ailure				10	Yes 2□No	3 🗌 Probi	ably 4 Unknown
000	aw requir s been si 2 should l	piet						24a. Was		ere autor	osy findings available
ž	hysician: The law his certificete has I I director, pege 2 s	Completed						autor perfo	osy pr irmed? de	nor to con eath? Yes	npletion of cause of
<u>ta</u>	artifica etor.	Be	25. Was case referred to medical examiner?			_	26. Place of Deat		-		20110
<u>~</u>	hysic nis ce I dire	၉	1 ☐ Yes 2 No	fospital: 1 ⊠Inpatient 2□	ER/Outpatien	3 □ DOA Othe	f: 4 Nursing Ho	me 5 Resid	dence 6 Othe	r (Specify	•)
ouo	Attending Physician: r death. sctor: After this certifict by the funeral director.		27. Manner of Death  1 ☑ Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	at ? ′es 2 □ No	28d. Describe I	now injury occurre	d	
Division of Vital Records,		Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specification)	ome, farm, stre			28f. Location (S City or Tox	Street and Numbe vn, State)	r or Rural	Route Number,
_	To the Hospitel or within 24 hours after To the Funerel Dir completely filled in		29a. Certifier 1⊠ Certifying Phys	sician: To the best of my kno	owledge, death	occurred at the time	e, date and place.	and due to the	Cause(s) and man	ner as et:	ated
	24 h	Medical	(Check only 2 Medical Examination)	ner: On the basis of examina and manner stated.	ition and/or inv	estigation, in my op	inion, death occurr	red at the time,	date and place, ar	nd due to	the cause(s)
	To the To the Comp	ž	29b. Signature and title of certifier			29c. License	number		29d. Date signed	(Month, L	Day, Year)
)	/		I frolly			20	2767		7-5-06		
	5		30. Name and address of person who co				D = a1 ! 1 1	- MD 0	0010		
	Sta	20	Ram S. Trehan, M.I  31. Date filed (Month, Day, Year)	). 1400 Forest			KOCKVIII	e, MD 2	0910		
*	Registr	_	JUL 1 1 200	32 Registrar's Signa	1. Goa	all of					

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Conten, ESTHER

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month George William Cole 27, 2006 2105 June 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Fort Washington Hospital Fort Washington
| If Under 1 Year | If Under 24 Hrs. | 8. |
| Months | Days | Hours | Min. | 6. | Prince Georges 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1**⊠**M 2□F 577-72-5150 53 Nov. 3, 1952 Wash., DC Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 1-Yes 2 □ No PG Md. Fort Washington 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 8108 Holiday Avenue 20744 United States 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☑ No Specify: 3 Widowed 4 Divorced **Black** 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) VIP Driver Dept. of Army 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Unknown Alice Hill 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Holiday Avenue 8108 Fort Sandra Cole/wife 2074 1 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 ☐ Burial 2 IXCremation 3 ☐ Removal from State Riverdale Crematory 7/6/06 4 ☐ Donation 5 ☐ Other (Specify) Riverdale, MD. 21. Signarde of Funeral Service Licensee 22. Name and Address of Facility Hodges & Edwards F.H. 3910 Silver Hill Rd., Suitland, MD. 20746 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Immediate Cause (Final disease or condition resulting in death) Onset and Death ardiom Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Yes 2 No 1 ☐ Yes 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: 1 ☐ Inpatient 2 XER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Tes 2 No 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No 2 ☐ Accident 6 Could not be 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1 \*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 \*\*Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

death (Item 23a) (Type, Print)

Allen

10051194

29d. Date signed (Month, Day, Year)

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Examiner the attending physicien and shed for use as the burial-transit certificate be executed Box 68760, P.O. δ signed b Records, been si should has of Vital Physicien: To the Funeral Director: After this certific completely filled in by the funeral director. Division Attending death. within 24 hours efter To the Funeral Dire To the Hospitel or

**Physician** 

/Medical

Examiner

Directo

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Be

**Funeral** 

Director

r than "naturel", or items 23e or 28e-f ehow the Medical Examinar must be notified at

is marked other than

permit. Pages 1 and 2 should be file Department of Heelth and Mental Hy Important: If Item 27 Is marked oth eny injury or other treumatic event <u>apps.</u>

**Physician** 

/Medical

Examiner

Physician/Medical

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Completed

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Certification:

Medical

29a. Certifier

29b. Signature and title of certifie

30. Name and address of perso who completed us o

detached

page 2 :

Maryland 21215-0036

Baltimore,

State Registrar DHMH 17 Rev 1/2001 prona 2. Registrar's Signature

5801

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death July 9, 2006 **Physician** 12:45 P Bettv Collins /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Ft. Washington Hospital Ft. Washington Prince George's If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Hours Months 1 M 28 MF Yrs. Director West Virginia <del>232-42-2659</del> June 10, 1930 Usual Residence of Decedent with the Maryland 10a, State 10b. County 10c. City, Town or Location 10d. Inside City Limits itam 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Madical Examinar must be notified at 1 ☐ Yes % No Prince George's Maryland Oxon Hill Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5107 Wheeler Road 20745 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2XXNo If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑XNo White Specify þ 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Homemaker In Home 12 permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Itam 27 is marked other sny injury or other traumatic event. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Claude Smith Ethel Jones 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Linda Hines / Daughter 5107 Wheeler Road Oxon Hill, Maryland 20745 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 Cremation 3 ☐ Removal from State Kalas Crematory 07/11/2006 4 ☐ Donation 5 ☐ Other (Specify) Edgewater, Maryland 22. Name and Address of Facility George P. Kalas Funeral Home P.A. 21. Signature of Figneral Service Licensee wann 6160 Oxon Hill Road Oxon Hill, Maryland 20745 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician days Due to (or and consequence of): /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last n Due to (or as a consequence of): Examiner The law requires that the death certificate be executed been signed by the ettending physicien and should be deteched for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medical IF FFMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy in the past 12 months? Month Day Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 🎖 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an s certificate has blirector, page 2 s autopsy 1 Yes 2 No or Attending Physician: 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٥ 1 Inpatient 2 ER/Outpatient 3 DOA funeral dir 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 28c. Injury at Work? Certification: After Injury 1 Naturat 5 Pending 1 ☐ Yes 2 ☐ No М death. investigation 2 ☐ Accident after deat 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 T Homicide the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a, Certifier cal To the Ho within 24 h Medi 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and titte of certifier 7/10/2006 00060920 PHYSICIAN 9131 Piscataway Rel #240 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 0 YUDNINE N. RUDDER, MD no 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 2006 Registrar

			1- State of M	-	artment of Health and		giene	23348
3	Physic /Medi		1. Decedent's Name (First, Middle, Last)  Don's E Cannon	\		2. Date of Dea Month		3. Time of Death
2	Examir		4a. Facility Name (If not institution, give street and number Chester Kiver Hospita	al Center	4b. City, Town, or Location of De Chester 10 If Under 1 Year   If Under 24 F	wn	4c. County of Dea	h —
	Funeral Director	£	214-32-0164 1□ M 2∏ F Usual Residence of Decedent	71 Yrs.		lrs. 8. Date of Birth (Month, Day 07/07		hplace (State or Foreign untry)  MD
	he Marylan 8a-f show	Director	MD Queen Anne's	10c. City, Town or Lo	lle			10d. Inside City Limits 1 XYes 2 ☐ No
10	72 hours after death with the Maryland natural', or items 23a or 28a-f show dical Exampler must be published at	Funeral Dire	10e. Street and Number  112 Price Street  11. Marital Status  1 Never Married 2 Married 1 Yes 2 (2)	? 1	10f. Zip Code  21617  Vas Decedent of Hispanic Origin? Yes, specify Cuban, Mexican, Pu		USA  14. Race - Ame Black, Whit	rican Indian,
21215-0036	72 hours a 'natural', or dical Exam	by	3 Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade completed)	16a. Deced	□ Yes 2 No Specify:  lent's Usual Occupation kind of work done during most of v	vorking	Specify: W	hite Industry
d 2121	be filed within 72 ho ital Hygiene. id other than "natur event, the Madical	• Completed	Elementary/Secondary (0-12)  1 1  17. Father's Name (First, Middle, Last)	life. [	NOT use retired)	lame (First, Middle, I	Educat	ion
Maryland	should be nd Mental marked o	To Be	Benjamin Franklin Nic		Mary	Elizabe	eth Hickm	
	1 and 2 Health a em 27 is ther treu	100	19a. Informant's Name/Relationship (Type, Print)  Vera L. Dixon/Daughte  20a. Method of Disposition		g Address (Street and Number or Springfield W sition (Name of	ay Dover		04
Baltimore,	t. Page rtment o rtant: If njury or		1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation, 5 ☐ Other (Specify)  21. Signatus of Funeral Service Licensee	Cheste	rfield Cem 07	/07/2006	Centre	ville, MD
B	Depa Impo any la		23a. Part 1. Enter the disease, or complications that cause	the death Do not enter	llows, Helfer 8 S. Liberty S	bein & M	Newnam Fu	neral Home D 21617 Approximate
	Physician /Medical		snock, or heartfailure. List only one cause on each I Immediate Cause (Final disease or condition resulting in death)	ine.	AGE COP	D	531,	Interval Between Onset and Death
8760,	e be executed sicien and purial-transit	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events . c.	a consequence of):				,
O. Box 6	that the death certificate be executed ted by the attending physicien and detached for use as the burial-transit	Physiclan/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	2 Fetal death 3	Ectopic pregnancy Other (specify)		23d. Date of deli Month	very Day Year
<u>α</u>	86 20 90	þ	Part II. Other significant conditions contributing to death b	ut not resulting in the un	derlying cause given in Part I,		pacco use contribute to	the cause of death?
Vital Records,	The ate h page	Completed				24a. Was ar autops perforn 1 □ Yes 2	y prior to d	topsy findings available ompletion of cause of
f Vita	Physicien: Th this certificate ral director, pag	To Be	25. Was case referred to medical examiner?  1  Yes 2 No Hospital: 1 Impatie	ent 2 ER/Outpatient	Oth ==	eath Check only one	nce 6 Other (Spec	ifv)
Division of	ding h. After fune		27. Manner of Death  1 Natural 5 Pending (Month, Da 2 Accident investigation	y Year) 28b. Time of Injury	28c. Injury at Work? M 1 Yes 2 No	28d. Describe ho		
Divis	or At after of Direction by	Certification	4 Homicide building, et	ury - At home, farm, stre c. (Specify)		City or Town	,	
	he Hospital in 24 hours in he Funeral pletely filled	edical	29a. Certifier (Check only one)  1 Certifying Physician: To the best 2 Medical Examiner: On the basis of and manner st.	t examination and/or invi	occurred at the time, date and pla estigation, in my opinion, death oc	ce, and due to the ca curred at the time, da	use(s) and manner as ate and place, and due	stated. to the cause(s)
)		2	29b. Signature and title of certifier	· mo	29c. License number		od. Date signed (Month)	, Dey, Year)
6	) ms		30. Name and address of person who completed cause of c Patrick J. Shanahan H	eath (Item 23a) (Type, F	Print) Deex RO Blog B	Chester	town Min	211025
	Sta Registr		31. Date filed (Month, Day, Year) 32. Registres 5 2006	s Signature	Les Asi			

	_		1 - For State Registrar		ryland / Depa <i>Ce</i>	artment of H			giene Reg. No. 2	006	23349
	Physic /Medi Examir	cal	Decedent's Name (First, Middle, Last     Marilyn Marshall     Aa. Facility Name (If not institution, give	Chu		4b. City, Town, or	Location of De	2. Date of De Month July 8	, 2006	Year y of Death	3. Time of Death 3:28 P M
	Funeral Director		Casey House 5. Social Security Number 388-48-2776 6. Se	x 7. Age	(In yrs. last birthday) 56 Yrs.	Rockvill  If Under 1 Year  Months Days	e If Under 24 H Hours Mi			Cour	place (State or Foreign
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural; or iteme 23s or 28a-f show any injury or other traumatic event, the Middial Examinar must be notified at once.	To Be Completed by Funeral Director	Usual Residence of Decedent  10a. State  10b. County  Maryland Frederick  10e. Street and Number  1320 Rosemont Driv  11. Marital Status  1 Never Married 2 Marned  3 Widowed 4 Divorced  15. Decedent's Edu (Specify only highest grad  Elementary/Secondary (0-12)  17. Father's Name (First, Middle, Last)  William Kenneth Ma  19a. Informant's Name/Relationship (Ty  Kathleen Marshall/  20a. Method of Disposition  1 Burial 2 Moremation 3 F  4 Donation 5 Other (Specify)  21. Signature of Funeral Service, Eicenty	e  12. Was Decedent E Armed Forces?  1	16a. Dece (Give iffe.) Offic 19b. Mailir 478 D. 20b. Place of Dispo cometery, crer Chesapeak.	10f. Zip Code 21758  Was Decedent of Hiff Yes, specify Cuba 1 Yes 2 XNo  Ident's Usual Occupp kind of work done of DO NOT use retired  Manager  ag Address (Street at a ger Spr  sition (Name of natory or other place)	Specify:  ation furing most of w  18. Mother's N  Joan Ok  and Number or I  in Roa  b)  ry 07/ s of Facility	(Specify Yes or No orto Rican, etc.)  rorking  ame (First, Middle, Opinski  Rural Route Number and Earle Date	10g. Citizen of USA  14. Ra Bla Specia  16b. Kind of E  Law Fir  Maiden Suman  Rock, V  20c. Location  Celtsvi	What Cour ce · Americ ck, White, fy: Whi Business/Inc rm me) VA 24( - City or To	can Indian, etc.  te dustry  Code) 085 wn, State
J. BOX 68/60,	Care to entificate be executed be executed by Imperior and be attending physicien and ed for use as the burial-transit	hysiclan/Medical Examiner	Sequentially list conditions, a.y. loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2√2 No	Due to (or as a	ancer consequence of):  astases consequence of):  consequence of):  pregnancy Fetal death 3	er the mode of dying  Ectopic pregnancy  Other (specify)	g, such as cardi	ac or respiratory ar	23d. Da	te of delive	Approximate Interval Between Onset and Death  Onset and Death
records, P.C	The law requires that the death certific ste hes been signed by the atlending p page 2 should be detached for use as	Completed by Phy	9 □ Unknown Part II. Other significant conditions con		not resulting in the ur	iderlying cause give	n in Part I.		es 2 No an 24b. sy med?	3 Proba	e cause of death?  ably 4  Unknown  asy findings available apletion of cause of
ivision of vital	To the Hospital or Attending Physician: The law within 24 burus after deads. To the Funeral Director: After this certificate hes completely filled in by the funeral director, page 2	Certification; To Be C	25. Was case referred to medical examiner?  1 Yes 2X No H  27. Manner of Death  1X Natural 5 Pending investigation  3 Suicide 6 Could not be determined	ospital: 1 Inpatient 28a. Date of Injury (Month, Day) 28e. Place of Injury building, etc.	28b. Time of Injury	28c. Injury Work M 1 \( \sup Y	r: 4 🗆 Nursing	eath Check only of Home 5 Resid 28d. Describe h	ence 6 XOth ow injury occurr	er <i>(Specify</i> red	Hospice
נ	o the Hospital c	Medical Cer	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin  29b. Signature and title of certifier	ician: To the best of ter: On the basis of e and manner state	my knowledge, death	occurred at the time estigation, in my op	inion, death occ	e, and due to the courred at the time, of	ause(s) and ma late and place,	and due to	the cause(s)
910	<b>∂</b>	-	30. Name and address of person who con			D3563.	5	J	uly 10,		
	Sta Registra		Joseph Kaplan, M.D  31. Date filed (Month, Day, Year)  JUL 1 2 20	32. Pigistrar'				, ru 2085	5		

06-05028 Teresa F Cox

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

	- 1	I-For State						of Death	)		-	eg No.	400	5 2330
Physicia	1/4	1. Decedent's Nam		· ·							<ol><li>Date of Deat Month</li></ol>	Dav	Year	3. Time of Death
Medical Examin		Teressa 4a Facility Name (i						I de Chu T	own, or Locatio	n of Dooth	July 14, 20	006	unty of Death	0602 hrs
		Penninsula						Salsbi		II OI Dealli			omico	
Funeral	7	5 Social Security N	lumber	6. Sex	7. Age	(In yrs. las	t birthday)	If Unde	1 Year If Ur	nder 24Hrs.	8 Date of Bir	th(MM/DD/		hplace (State or
Director		214-78-79 Usual Residence o		1 M 2	XF	46		Months	Days Hou	urs Min.	03-24-	1960	Foreig Cou	n <sup>untry)</sup> MD
any	Ì		10b. County			10c. City, T	own or Lo	cation	_		-			10d. Inside City Limits
Maryland 28a-f show 1 at once.	5	MD	Wicomi	.co		Salis	burv							1 Yes 2 X No
Maryla 28a-f	Director	10e. Street and Nu				<u> </u>		10f. Zip	Code		11	Og Citizen	of What Cour	try?
th the Maryland 23a or 28a-f sho notified at once.	₫	Keen Aver	iue, Ar	t. #8					21801			USA		
th wit	Funeral	11. Marital Status  1 Never Marri		12. V	vas Decedent E rmed Forces?		. 13.	Was Deceder f Yes, specify	it of Hispanic C Cuban, Mexic	rigin? ( Spe an, Puerto F	ecify Yes or No- Rican, etc.)		Race - Ameri White, etc.	can Indian, Black,
er dea		3 Widowed		orced if Yes,		X No	1	Ves 2	No speci	fu		Sno	cify: Whi	<b>.</b> .
hours aft "natural" Examine	핡	15. Decedent's Ed		or Dat	es.	oleted)		ent's Usual (	occupation (Giv	ve kind of wo			of Business/I	
72 hor "na al Exa	Completed	Elementary/Seco	ondary (0-12)	Co	ollege (1-4 or 5	+)	during	most of work	ing life. DO NO	OT use retire	ed)			
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2121: wid be fi Mental I marked c event,	To Be	Theodore			int )		19b. Mai	ling Address	(Street and N	dys M:	iller ural Route Num	ber. City or	Town State	Zip Code)
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o, 15 5 5 7	Ī	Theodore 20a. Method of Dis					ace of Dis	osition (Namother place)	e of cemetery,		Date		ition - City or	
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Baltimore, permit. Pages I at Department of He Important: If ite	ŀ	21. Signature of Fu			1/1	1	22	. Name and	Address of Faci	lity Bo	ounds F	unera	1 Home	
		1/flood	Jac.	41.19	alle	r	7	05 Eas	t Main	Stree	et, Sal	isbur	y, MD	
Physician /Medical	ł	28a, Part I. Enter the failure. List on		on each line						s cardiac or	respiratory arre	est, shock, (	or heart	Approximate Interval Between Onset and
Examiner		Immediate Cause ( or condition resulti	Final deease		herosclei (or as a conse			<i>r</i> ascular	disease					Death
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760, ficate be g physici		IF FEMALE: 23b. Was decedent	pregnant in th		If yes, outcom	e of pregna		Fatal doath	3 Ecto	nic prognan	101	23d. Da Mor	ate of delivery	ay <b>Y</b> ear
OX 687 eath certific	ciar	past 12 months	-	4	Pregnant at t	ime of dear	2 th _5	Fetal death Other (Spec		pic pregnan	icy	IVIO	III D	ay Year
Box   e death of the attented for us	Physician	1 Yes 2		3	Unknown									
ires that the signed by 1	e P	Part II. Other signi	ficant condit	ions contri	outing to death	but not res	sulting in th	e underlying	cause given in	Part I.			E =3	he cause of death?
Division of Vital Records, P. ral or Attending Physician: The law requires th ras after death.  "I Director: After this certificate has been signe led in by the funeral director, page 2 should be de	힣	-								-	24a Wasa			ably 4  Unknown  opsy findings available
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Visi or Att fifter de Directe	ifica	2 Accident 3 Suicide	- 🖂	d not be	Be. Place of Inju	ury - At hor	ne, farm, s	treet, factory,	office building,	etc.			lumber or Rur	al Route Number, City
Division  Hospital or Attent 24 hours after death Finneral Director:	Certification:	4 Homicide			Specify)						or Town, S	iale)		
Division of Vital Records, P.O. Box 68' To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as		29a. Certifier (Check only one)		-							due to the caus			
To the within 7 To the complet	Medical	29b. Signature and		and m	nanner stated.				License numb				signed (Mon	
		1	1 A3	Ma. n.	1 200				O.C.M.E.			July 15		, , ,
		30 Name and add	y VU	who comple	ted cause of de	eath (Item 2	23a)			-		<u> </u>		
-		Pamela So	uthall, MD	Assista	nt Medical	Examine	er 111	Penn Str	eet, Baltimo	ore, MD 2	21201			
	ate	31. Date filed (Mon		0 2006	32. Registrar		e Ag	Carle						
Regist	ŒЦ			U CUUU	3.14 E.21 A.	Charle So	7 50	Color of the			_			j.

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Dorothy Estelle Cooksey JULY 10 2006 2:20 A<sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner CIVISTA MEDICAL CENTER LAPLATA CHARLES 8. Date of Birth (Month, Day, Yea Aug. 24, If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday If Under 1 Year Year) 1921Washington DC **Funeral** Days Hours 1 □ M 2X□ F 84 Yrs. 577-20-6852 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d, Inside City Limits 1 ☐ Yes Ž☐ No Funeral Director Maryland Charles Waldorf 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20603 US 3505 Twinbrook Drive 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ②No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status r than "natural", or Itan 1 Never Married 2 Married White 1 ☐ Yes 2 No Specify: Specify Be Completed by 3 X Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Hygiene. Homemaker Own Home 27 is marked other traumatic event, t Department of Health and Menter in Insportant: If Item 27 Is any Injury or other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Fannie J. (unavailable) William Franklin Blake ၉ 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 31 Farber Drive, Chalfont, PA 18914 Janet M. Palmer - Daughter 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-13-2006 Cedar Hill Cemetery Suitland, Maryland e of Fundal Service Lice 22. Name and Address of Facility 3035 Old Washington Road M00053 Huntt Funeral Home POB 156, Waldorf, MD 20604 or complications hat caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, ist only only cause on each line. 23a. Part1 Enter the disease, or comshoot, or heart failure. List only Approximate interval Between Onset and Death NEWMONI Immediate Cause (Final Physician disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner AEMOSCUENOST Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner attending physician and for use as the burial-transit resulting in death) Last a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 2 No 3 Probably 4 Unknown 1 🗌 Yes Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? page 2 s autopsy performed 2 No 1 ☐ Yes 2 ☐ No 1 Yes 25. Was case referred to medical examiner? 26. Place of Death | Check only one Hospital: Other 4 Nursing Home 5 Residence 6 Other (Specify) 1 Npatient 1 ☐ Yes \_ No 2 2 ER/Outpatient 3 DOA this After thi 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 Natural 5 Pending investigation s after dec. 1 Yes 2 No 2 Accident 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, faclory, office building, etc. (Specify) To the Hospitel or Atte within 24 hours after de To the Funeral Direct completely filled in by ti 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide 1x Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a Certifier Medical (Check only one) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D-20629 ess of person who completed cause of death (Item 23a) (Type, Prince GEORGE H WATHEN MD 11345 PEMBROOKE SQ. STE 103 WALDORF, MD 20603 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 1 1 2006 Registrar

filed within 72 hours after

The law requires that the death certificate be executed

Box 68760.

P.O.

Records,

Division of Vital or Attending Physicien:

			For State Registrar	State	of Marylan		artment of H			-	giene Reg. No.	200	16.	2335
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100	D		Usual Residence of Decedent										<u> </u>	Lingcon I
	rylan		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation						10	d. Inside City Limits
	9 Ma	<b>8</b>	Maryland St. I	Marys	Ch	arlot	te Hall							1X Yes 2 □ No
	or 24	Director	10e. Street and Number				10f. Zip Code				10g. Citiz	zen of Wha	t Count	ry?
	ath w		37546 Sunrise				2062					SA		
	er de	Funeral	11. Marital Status	Armed F			Was Decedent of F f Yes, specify Cub	Hispanic Orig an, Mexican	gin? (Spec i, Puerto F	cify Yes or No Rican, etc.)	1	14. Race - / Black, \		
30	be filed within 72 hours after death with the Maryland lat Hygiene. d other then "natural", or items 23e or 28e-1 show event, the Malical Examiner must be notified as	by F	1 ☐ Never Married 2 ☐ Married 3 🔀 Widowed 4 ☐ Divorced	ff Yes, G Year or I	2X No ive		1 ☐ Yes X☐ No	Specify:				Specify:	D1-	1-
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a S	2 should land Menie marke		19a. Informant's Name/Relationship	Type, Print)		19b. Mailin	g Address (Street	and Numbe	r or Rural	Route Numbe	er, City or	Town, Sta	te, Zip (	Code)
	s 1 and 2 should if Health and Men item 27 ie marke other traumatic		George Curtis	/ Son		3754	6 Sunri	se Lr	ı. Cl	harlot	tte	Hall	MD	20622
<u>e</u>	es 1 a of He fiter		20a. Method of Disposition	10		Place of Dispo	sition (Name of natory or other pla	1	Da			cation - Cit		
Ĕ	Pages nent of int: If it		1X Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Speci		State		Memori	'	7/13	/2006	Wal	dorf	. M	aryland
altimore,	permit. Pages Department of important: If is any injury or o		21. Signature of Surjeral Service Lice	Dege )		22	. Name and Addre	ss of Facility	y Adar	ns Fiir	nera	1 но	me	PA
<b>n</b>	80558		Zhyl E	45	191	2	0605 Aq	uasco	Rd	Aquas	sco,	Mar	yla	nd 20608
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that	caused the deat each line.	h. Do not ent	er the mode of dyir	ng, such as	cardiac or	respiratory a	rrest,			Approximate Interval Between
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	/Medical Examiner		resulting in death)	Due to	(or as a conseq	_								
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8/60	icate be executed physician and s the burial-transit	aiE				,								
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XOR	death certifi e attending p id for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant		tcome of pregna						2	3d. Date of	deliver	v
ă	death e atte d for	icia	in the past 12 months? 1 ☐ Yes 2 ☒ No	4 <u>□</u> Preg	birth 2∏Feta nant at time of d		]Ectopic pregnancy ] Other <i>(specify)</i>	y 				Month		Day Year
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_	signed be de	by P	Part II. Other significant conditions	contributing to	death but not res	ulting in the ur	nderlying cause giv	ren in Part I.	į.	23e. Did to	obacco us	se contribu	te to the	cause of death?
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Vital	Physicien: The law this certificate has I ral director, page 2 s	Be	25. Was case referred to medical examiner?		1.0.				of Death	(Check only o	ne)			
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	or the land	ion	27. Manner of Death 1. Natural 5 ☐ Pending		of Injury oth, Day Year)	28b. Time of Injury	28c. Injur Wor M 1 🗆	yat rk?  Yes 2.∐.N		3d. Describe I	10w infury	occurred		
DIVISION	Attending ir death. ector: After by the fune	lcat	2 Accident investigation 3 Suicide 6 Could not be	18 20a Blas	e of Injury - At h	ome farm str	eet, factory, office	162 2   1		Rf Location /	Street and	1 Number o	r Dural	Route Number,
≧	aftar Dire	Certification;	4 Homicide determined	build	ling, etc. (Specif	y)	oot, ractory, office			City or Tov	vn, State)	710111001	7 7 10721	riodio ridinosi,
	spits hours inerel y filled		29a. Certifier 1∑ Certifying PI	nysician: To th	e best of my kno	wiedge, death	occurred at the tir	me, date and	d place, ar	nd due to the	cause(s)	and manne	r as sta	ted.
	he Ho in 24 he Fu pletel	Medical	(Check only 2 Medical Example)	miner: On the t and mar	pasis of examina nner stated.	ition and/or inv	estigation, in my o	pinion, deat	h occurred	d at the time,	date and	place, and	due to t	the cause(s)
	To the Hospital or Atlandi within 24 hours aftar death. To the Funerel Director: A completely filled in by the fu	Σ	29b. Signature and title of certified	h/			29c. Licens	e number			29d. Date	signed (M	onth, D	ay, Year)
•			INNI	5			D460	65			July	11,	20	06
<	10		30. Name and address of person who											
	DD		Nader A. Dakak 31. Date filed (Month, Day, Year)	M.D. 8	401 Co	lesvi	lle Rd	#310	Sil	ver S	orin	g MD	20	910
	Sta Registr		JUL 1 2	2006	Maguar s Signa	H. 1.	boards 3							
	3.011		207 7 4			4.								

			1 - For State Registrar	State of Maryla		artment of Hertificate of L		Mental Hygie	ZUUb	23353
			Decedent's Name (First, Middle, Last)					2. Date of Death		3. Time of Death
	Physici /Medio		JOHN	WILLIAM I	OWYER			JUNE 28	B 2006 Year	6:04P M
	Examir		4a. Facility Name (If not institution, give			4b. City, Town, or			4c. County of Death	
			WASHINGTON ADVEN			SILVE.	R SPRING	1	MONTGOM	
	Funeral Director		5. Social Security Number 6. Security Number 15.	IM 2□F	i. last birthday) Yrs.	Months Days	Hours Min.	(Month, Day, Ye	ear) Cou	place (Stete or Foreign ntry) Y, IN
			Usual Residence of Decedent	69				JUNE 17	1937 GAR	1,11
	rylan how		10a. State 10b. County	10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	8a-1	cto	MD PRINCE GE	ORGE'S	LAUR	EL				1X Yes 2 □ No
	ith th	Dire	10e. Street and Number	T		10f. Zip Code	0	10g.	. Citizen of What Cou	ntry?
	s 23s	ral	9000 BRIARCROFT LAN		1.0	2070			U.S.A.	and to disco
36	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "naturel", or items 23e or 28e-f ehow any fujury or other traumatic event, the Medical Examinant intelliging any page.	by Funeral Director	11. Marital Status  1 □ Never Married 2 □ Married  3 □ ※Widowed 4 □ Divorced	12. Was Decedent Ever in Armed Forces? 1 XYes 2 No If Yes, Give Year or Dates:	A 3737	Was Decedent of His If Yes, specify Cubar 1 ☐ Yes 2፟\(\tilde{\tilde{M}}\) No	spanic Origin? (S n, Mexican, Puert Specify:	реслу Yes or No- o Rican, etc.)	14. Race - Ameri Black, White	
21215-0036	2 hou	ted	15. Decedent's Edu	cation	16a. Dece	dent's Usual Occupa	tion	168	b. Kind of Business/Ir	
215	thin 7 8.	Completed	(Specify only highest grade Elementary/Secondary (0-12)	College (1-4or 5+)	life.	kind of work done d DO NOT use retired)	uring most of wor	king		
7	ed wi	S	8th		CH	IAUFFER			PRIVATE	
Maryland	be fill d off	Be	17. Father's Name (First, Middle, Last)  JULES DWYER				18. Mother's Nar	ne <i>(First, Middle, M</i> ai ru	den Sumame) BYNES	
2	d Mer narke	٩	19a. Informant's Name/Relationship (Ty.	an Orian	105 14-15	A 44 (Ct)				
Z	d 2 sl th an t7 is r traur		DARIAN ELLIOTT/DA					ral Route Number, C JPPER MARL		
	tem tem other		20a. Method of Disposition	20b.	Place of Dispo	sition (Name of		Date 20d	. Location - City or T	own, State
Baltimore,	Pages ent of nt: # I		1 ☐ Burial 2 ☑ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State		natory`or other place E CREMATOI	1	2006 RT	VERDALE, M	ARVI.AND
a E	mit. I partm portai y Inju	1	21. Signature of Funeral Service Liquid			. Name and Address		J. B. JENK		
m	88 = 8		C Ca		7	474 LANDOV	VER ROAD	LANDOVER,	MARYLAND	20785
	Physician /Medical Examiner	Examiner	23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse	quence of): quence of):	CARDIA	LIN	IFARC- LIDENT	- 1	Approximate Interval Between Onset and Death  Mod 74  WEEKS
<ol> <li>Box 68760,</li> </ol>	The law requires that the death certificate be executed sie hes been signed by the attending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical Ex	IG GEMALE:	Due to (or as a conse	nancy af death 3 [	Ectopic pregnancy			23d. Date of deliv	ery Day Year
О. О.	hat th ad by detach	Phy	Part If. Other significant conditions con	tributing to death but not re	sulting in the u	nderwing cause give	n in Part I	23e Did tobac	co use contribute to t	he cause of death?
Records,	requires t een signe tould be o	ted by							2 □ No 3 □ Pro	
al Rec	a S C	Completed						24a. Was an autopsy performed	prior to co	opsy findings available impletion of cause of
≝	Physician: Th r this certificete ral director, pag	Be	25. Was case referred to medical examiner?	ospital:		t 3 DOA Othe		th (Check only one)		
Division of Vital	ding After	tion: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work	4 🗆 Nursing n	ome 5 Residence 28d. Describe how i		(y)
Divis	tal or Attendes s efter deatl al Diractor: ad in by the	Certification:	3 Suicide 4 Homicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	nome, farm, str ify)	eet, factory, office		28f. Location (Stree City or Town, S	t and Number or Run late)	al Route Number,
	To the Hospital within 24 hours of Fo the Funeral I completely filled	edicai	29a. Certifier 1 Certifying Physical Check only one) 2 Medical Examin	sicien: To the best of my kr ner: On the basis of examin and manner stated.	owledge, deatl ation and/or in	n occurred at the time vestigation, in my op	e, date and place inion, death occu	, and due to the caus rred at the time, date	e(s) and manner as s and place, and due t	stated. the cause(s)
	Within 5 and	W	29b. Signature and title of certifier	Altend.	Phys.	29c. License	number 9897		C, 29, 0	
W			30. Name and address of person who co		m 23a) (Type, AMOV	Print) PKW	y GRI	er NBE	to mo	20770
	Sta Registr		31. Date filed (Month, Day, Year) JUL 0 7 2006	32. Registrar's Sign	Park.					

#### Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) **Physician** 1.40 BM 5,2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Hound -6.9 real Hosph Gen If Under 1 Year | If Under 24 Hrs. 9. Birthplace (State or Foreign WASH., DC Social Security Number 6. 5 7. Age (In yrs. last b Months Hours 579-66-2951 47 Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a, State 1 Ves 2 No Completed by Funeral Director MD BALTIMORE 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code 21075 U. S. A. 7687 OLD ROCKBRIDGE DRIVE 12. Was Decedent Ever in U.S. Armed Forces? 1 XX Yes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 Yes XX No Specify: BLACK 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) YEARS U. S. POSTAL SERVICE SUPERV1SOR 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) JAMES CLIFTON DAVIS MARGUER1TE KENT 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7687 OLD ROCKBRIDGE DRIVE BALTIMORE, MD 21075 TANYA R. DAVIS---WIFE 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State LINCOLN CEMETERY 7-10-06 \* 4 ☐ Donation 5 ☐ Other (Specify) BRENTWOOD. 22. Name and Address of Facility PINCKNEY-SPANGLER FUNERAL HOME 21. Signature of Euneral Service Licensee 524 - 8TH STREET, N. E. WASH., DC 20002 23a. Part1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on each line. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Metastatic 6wks Due to (or as a consequence of) Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause Disease or injury that initiated events Examiner Due to (or as a consequence of) resulting in death) Last Due to (or as a consequence of) Completed by Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Failure 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 1 Yes 2 No 24a. Was an autopsy performe 1 Yes 2 1 No 25. Was case referred to medical Be 26. Place of Death (Check only one) Hospital: 1 Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State)

burial-transit The law requires that the death certificate be executed P.O. Box 68760. Division of Vital Records. To the Hospital or Attending Physician: After after death. á To the Funeral Medical

**Funeral** 

Director

23a or 28a-f show

the Medical Exteringer must be notified at

5

"natural".

Pages 1 and 2 should be filed v fromt of Heath and Mental Hygis tant: If item 27 to marked other t jury or other traumatic event, th

permit. Pages 1 and 2 s Department of Health an Important: If item 27 to any injury or other trau

Physician

/Medical

Examiner

filed within 72 hours after death with the Maryland

Baltimore, Maryland 21215-0036

Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

(Check only one) 29b. Signature and title of certified

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

30. Name and address of person who completed cause of death (Item 23a) (Type, Print) elem

Registrar

29a. Certifier

10724 Liffle 31. Date filed (Month, Day, Year) 32. Registrar's Signature JUL 2006

State of Maryland / Department of Health and Mental Hygiene? 23355 1 - For State Registrar Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** 3 Daugherty July 2006 4:05 A /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death Examiner Crofton Convalescent Center Crofton Anne Arundel 5. Social Security Number 6. Sex Birthplace (State or Foreign Country) **Funeral** 1 M 2 XF 254-24-2196 Director Atlanta, GA Usual Residence of Decedent 10c. City, Town or Location 10b County 10a State 10d. Inside City Limits 27 is marked other than "natural", or itema 23a or 28a-f ehow traumatic event, its Madical Examinar must be notified at 1 X Yes 2 No Maryland Anne Arundel Crofton Directo 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? death with 2131 Davidsonville Rd. 21114 USA Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give<sup>2</sup> Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 2 should be filed within 72 hours after to and Mental Hygiene. 1 □ Never Married 2 □ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: Completed by Specify: White 3 Widowed 4 □ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper Food Service 2 Yrs 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Mary Couch C.C. Edgar ျှ Jet, Ma yermit. Pages 1 and 2 sho. Department of Heelin and M-important: if item 27 to any injury or min 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21144 Linda Pantsari/ Daughter 1300 Ava Rd. Severn, MD 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State July 8, 2006 Conway, SC Hillcrest Mausoleum 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility Beall Funeral Home 21. Signature of Funeral Service Licensee 6512 NW Crain Hwy. Bowie, MD. 20715 90 23a Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Physician Atherosclerotic Cardiovascular Disease disease or condition resulting in death) years /Medical Due to (or as a consequence of): Examiner Dementia W. ars Esquantially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed that initiated events nding physicien and resulting in death) Last Due to (or as a consequence of) P.O. Box 68760. Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy in the past 12 months?

1 Yes 2 No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9☐ Unknown 9 Unknown s been signed by the should be detact Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, Completed by 1 ☐ Yes 2 ☑ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificete 2 No 1 ☐ Yes 2 ☐ No 1 Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: ို 1 Inpatient 2 ER/Outpatient 3 DOA this 28a. Date of Injury (Month, Day Year) After thi funeral 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: To the Hospiter C. Swithin 24 hours after death.
To the Funeral Director: Altra-to-tally filled in by the fur 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 ☐ Suicide 4 ☐ Homicide 29a. Certifier 15 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the Medical Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 14300 Gallant Fox Lane #222 Bowie, MD. Rakesh Arora, M.D. 31. Date filed (Month, Day, Year)
JUL 0 7 2006 32. Registrar's Signatur State Registrar

State of Maryland / Department of Health and Mental Hygiene 23356 Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2<u>006</u> **Physician** Month Year Eunice DeBellotte 3,\_ 7:28 PM July /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 14209 Grand Pre Road #204 Montgomery Silver Spring | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Pay, Year) | 9. Birthplace (State or Fore Country) | 1934 | Trinidad, WI 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 ☐ M 2 □XF 72 Yrs. Director 214-60-1219 Usual Residence of Decedent filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits r than "natural", or items 23s or 28s-f show the Medical Examinar must be notified at Maryland Montgomery Silver Spring 1 Yes 2 □ No Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 14209 Grand Pre Road #204 20906 United States Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: Black 1 Yes 2 No þ Specify: 3 ☐ Widowed 4 X Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry permit. Pages 1 and 2 should be filed within 72 Department of Health and Mental Hygiene. Important; if item 27 is marked other than "nu sny injury or other traumatic event, the Meall once. College (1-4or 5+) Elementary/Secondary (0-12) Intelsat Corp. Hospitality Specialist 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Irving McLean Hilda Thomas 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12818 Odens Bequest Dr., Bowie, MD Tyburn B. DeBellotte 20720 (son) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 □Donation 5 □ Other (Specify) Maryland National 7/14/06 Laurel, Maryland 22. Name and Address of Facility McGuire Funeral Service 21. Signature of Funeral Service Licensee 7400 Georgia Ave. N.W., Washington, D.C. 20012 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Cardiopulmonary Arrest /Medical Due to (or as a consequence of) Examiner Congestive Heart Failure Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine burial-transit Hospital or Attending Physician: The law requires that the death certificate be executed Hypertensive Heart Disease Due to (or as a consequence of): attending physicien for use as the buria Division of Vital Records, P.O. Box 68760, Physician/Medica IF FEMALE 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of defivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐No Month Day Year 4□Pregnant at time of death 5 Other (specify) ate has been signed by the page 2 should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part f. 23e. Did tobacco use contribute to the cause of death? ۵ Atrial Fibrillation 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Be Completed Primary Cardiomyopathy 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes ※☐ No 24a. Was an this certificate 1 Yes 2 No funeral director, 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospitaf: 1 fnpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No Certification: To 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 27. Manner of Death 28d. Describe how injury occurred After s after dea. 1 X Natural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 - Homicide To the Hospital
within 24 hours a
To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medicai 29a. Certifier and manner stated. 29c. License numbe 29b. Signature and tiple of certifier 29d. Date signed (Month, Day, Year) 0 mmark 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Radhey Murarka, MD, 50 W. Edmonston Dr., Rockville, MD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 1 2008 Registrar

State of Maryland / Department of Health and Mental Hygiene 2 1 15 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** Month George J. Danforth 06 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Peninsula If Under 24 Hrs. Regional medical Center WICONICO 5. Social Security Number 9. Birthplace (State or Foreign Country)
Ohio Sex. r⊟m 2□F **Funeral** Days Hours 268-12-9234 87 Director Usual Residence of Decedent 10c. City, Town or Location 10a. State 10d. Inside City Limits r then "natural", or items 23e or 28e-f show the Medical Examiner must be notified at 1 Yes 2 No Director Delaware Sussex Rehoboth Beach 10e, Street and Number 10f Zip Code 10g. Citizen of What Country? 61 Westside Drive 19971 U.S.A. within 72 hours after death 12. Was Decedent Ever in U.S. Amed Forces?

1 Ayes 2 No
If Yes, Give 1942
Year or Dates: 1944 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 No 1942 White þ 3 Widowed 4 Divorced 1944 Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) Diamond & Metals Reclaimer Metallurgy marked other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Charles Warren Danforth Eliza "Bowditch" Department of Health and Important: if Item 27 is ma eny injury or other traums once. 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) William G. Danforth / Son 61 Westside Drive, Rehoboth Beach, DE 19971 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Gate of Heaven Cemetery Jul. 12,2006 Dagsboro, DE Parsell Funeral Homes & Crematorium 21. Signature of Funeral Service Licensee with 16961 Kings Highway, Lewes, DE 19958 23a Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) ATHEROSCUEROTIC HEART Pnysician /Medical Examiner Sequentially list conditions, if any, reading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Dusto (u. as a consequence of) Examiner attending physician and for use as the burial-transit Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetel death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4☐ Pregnant at time of death 5 Other (specify) ed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by page 2 should be PAFUMONIA 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown FAILURE 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an was autopsy performed? 1 Yes 25. Was case referred to medical examiner? Be director. 26. Place of Death | Check only one Hospital: 1 Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ٩ 2 ER/Outpatient 3 DOA this 27. Manner of Death 1 Natural 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred Certification: Hospital or Attending 5 Pending within 24 hours after death.

To the Funeral Director: Aft 1 ☐ Yes 2 ☐ No 2 Accident investigation 3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated. 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) Micholas Caprin ins. D34593 pleted cause of death (Item 23a) (Type, Print) 30. Name and address of person who co St. SALISBURY Md 21801 Nicholas L. Ogburn MD
31. Date filed (Month, Day, Year) 32. Be 1008 CARNOLL 32. Registrar's Signature State

DHMH 17 Rev 1/2001

Registrar

Maryland 21215-0036

			1- For State Registramend #4a Pe					lealth and N Death	Mental Hy	giene_ Reg. No.	000	40000
	* y		1. Decedent's Name (First, Middle, La	ist)					2. Date of De Month	eath Day	Year	3. Time of Death
	Physicia /Medic		Ronald Ray Dotts						July	07	2006	9:06 p <sup>M</sup>
	Examin		4a. Facility Name (If not institution, giv		Mabili	tation	4b. City, Town, o	or Location of Death		4c. Cou	inty of Death	
			Laurelwood Nursi							Cec	il	
	Funeral		5. Social Security Number 6. S	Sex 7.	Age (In yrs. I		If Under 1 Year	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	rth	9. Birthpl	ace (State or Foreign
	Director		298-32-0654	¥EM 2□F	66	Yrs.	Months Days	Hours Min.	Aug. 1	5. 193	9 Ohio	шу/
	ס		Usual Residence of Decedent									
	ylan		10a. State 10b. County		10c. City	, Town or Lo	eation				10	Dd. Inside City Limits
	Ma 	io	Maryland Cecil		Elkt	ton						1 AYes 2 No
	r 28	Directo	10e. Street and Number				10f. Zip Code			10g. Citizen	of What Coun	try?
	3a c		100 Laurel Drive				21921			Unita	d State	.c
	ms 2	Funeral	11. Marital Status	12. Was Decede	nt Ever in U.	S. 13. V	Vas Decedent of I	Hispanic Origin? (Sp	pecify Yes or No	o- 14. I	Race - America	an Indian,
0	r ite	F	1 ☐ Never Married 2 X Married	Armed Force				an, Mexican, Puerto	o Hican, etc.)		Black, White, 6	etc.
ဗ္ဗ	within 72 hours after death with the Maryland ene. than "natural", or items 23a or 28a-f show fra Modical Exaciling fraud be notified at	by	3 Widowed 4 Divorced	If Yes, Give Year or Date	s1957-1	1961	☐ Yes 2. 2 No	Specify:		Spe	whit	:e
21215-0036	2 ho	Completed	15. Decedent's E	ducation		16a, Deced	ent's Usual Occup	pation		16b. Kind o	of Business/Ind	
15	n"n	ple	(Specify only highest gr. Elementary/Secondary (0-12)	ade completed) College (1-4)	05.51)	lite. L	kind of work done OO NOT use retire	during most of world)	king			
7	iene iene ire tre	E	7	College (1-40	01 3+)	Aircra	ift Mecha	anic		Aviat	ion	
	Hygie other	BeC	17. Father's Name (First, Middle, Last	)				18. Mother's Nam	ne (First, Middle	, Maiden Sun	name)	
Maryland	ld be ental ked i	To B	John F. Dotts					Agnes B	uszkiew	iez		
7	Shou nd M mar	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailin	g Address (Street	and Number or Ru			wn, State, Zip	Code)
S	trac		Elaine Dotts/Wife			1/1	amore.	Drive No	rth Fac	t Mary	1 and 21	901
ď	1 ar Hea tem		20a. Method of Disposition		20b. PI	face of Disno	sition (Name of		Date		on - City or To	
ᅙ	nt of nt of t: If it		1 ☑ Burial 2 ☐ Cremation 3 ☐		te De	<sub>laware</sub>	Veterans	Ju1	y 12,	D 1		
ᆵ	t. P.		4 Donation 5 Other (Special 21. Signature 1) For Service Line	N)/	> Men	norial	Cemeter	y 20		Delawa		
Baltimore,	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If item 27 is marked other than "naturat", or items 23a or 28a-f show any injury or other traumatic event, the Modical Exactinar man be notified at ODCs.		21. Signatur There Service Liv					ess of Facility Cre				
_	40204		The to	-							, Maryl	and 21901
			23a. Fart1. Enter the disease, or com shock, or heart failure. List only	one cause on each	sed the death h line.	n. Do not ente	or the mode of dyl	ng, such as cardiac	or respiratory a	irrest,		Approximate Interval Between Onset and Death
k.	Physician		Immediate Cause (Final disease or condition	· /th	UNTIN	16700	G (1	brus				Chiset and Death
	/Medical		resulting in death)	Due to (or	as a consequ	ience of):	1					
4	Examiner		Sequentially list conditions	ь/\/	ALN	u fre	out.					
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	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events	c	75614	AL A						
o Ô	icate be executed physicien and s the burial-transit		resulting in death) Last	Due to (or	as a consequ	uence of):						
68760,	te be ysici	edical		d								
_	tifica ng ph as th										-	·
Вох	ath certif attending for use a	Ş	1F FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome	me of pregna		Ectopic pregnanc	.,		23d.	Date of deliver	ry
	deat e atte	Cla	in the past 12 months? 1 □ Yes 2 □ No	4□Pregnan	t at time of de		Other (specify) _	y 			Month	Day Year
0.0	that the death cer ed by the attendin detached for use	Physician/M	9 Unknown	9∐ Unknowr	n							
	Attending Physicien: The law requires that the death certil rideath. It death. Sctor: After this certificate has been signed by the attending by the funeral director, page 2 should be detached for use a	by P	Part II. Other significant conditions	contributing to deat	h but not resu	ulting in the ur	iderlying cause gi	ven in Part I.	23e. Did	tobacco use c	ontribute to th	e cause of death?
Vital Records,	uire n sig								1 🗆	Yes 2□N	o 3 ☐ Proba	ably 4 Unknown
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Š	has ge 2	E D							auto		prior to con death?	rpletion of cause of
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Ħ	iciar Sertif ecto	Be	25. Was case referred to medical examiner?	Hospital:				26. Place of Dea				
o o	this al dii	2	1 Yes 2 No 27. Manner of Death	1 Linps	atient 2 🗆		3 DOA	Nursing H	ome 5 Res			)
Ē	ding I h. After funer	O	1 ☑Natural 5 ☐ Pending		Day Year)	28b. Time of Injury	28c. Inju Wo		28d. Describe	now injury oc	curred	
sic	tend leath tor: , the f	cat	2 Accident investigation 3 Suicide 6 Could not be	na ——/—				]Yes 2□No				
Division of	or At after Direction by	ertification:	4 Homicide determined	28e. Flace of	tc. (Specify		et, factory, office		City or To	wn, State)	imber or Hural	Route Number,
	To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	O		11/								
	Hospitel 24 hours a Funerel (	Medical	(Check only 2 Medical Exa	hy ici (n. To the be nine) On the asi	s of examinat	wledge, death tion and/or inv	occurred at the ti estigation, in my	me, date and place, opinion, death occur	, and due to the rred at the time,	date and place	I manner as sta ce, and due to	ated. the cause(s)
	To the within 2. To the I complete	Med	one)	and manner	r stated.							
	To To Co⊓	2	29b. Signature and title of certifier				29c. Licen:	se number		290. Date sig	gned (Month, E	Day, Year)
	V .11	1	/ ///	1/2			1/)5	4015		10)	VL O6	
	5+11		30. Name and address of parso 170 o	mpleted cause of	of death (Item	23a) (Type,	Print)	,	1	1 ,	_ ^	- 1022
			Arley Szore	i m	B	1) Ct	WRITHM	ous U	12 /	10W LAS	INF DE	- 19720
	Sta		31. Date filed (Month Day, Yar)	2006 32.	istrar's Signat	ture	and i					
	Registr	rair .	AAL - N	LOUU   W								

	an	1. Decedent's Name (First, Middle, Las		ulin			2. Date of De Month	Jaly 04,200	3. Time of Death 2:30 a
Medio xamir		4a. Facility Name (If not institution, give			4b. City, Town, o	or Location of Dea	ath	4c. County of Dea	<u> </u>
neral ector		5. Social Security Number 6. Social Security Number 1  214-44-0738 1  Usual Residence of Decedent	D	yrs. last birthday) 55 Yrs.	If Under 1 Year Months Days	If Under 24 Hr		th 9. Bir y, Year) C	thplace (State or Foreigountry)  VA
fled at	tor	10a. State 10b. County  MD Anne Ar		c. City, Town or Lo	nold				10d. Inside City Limi
ust be not	al Director	10e. Street and Number 41 Church Road			10f. Zip Code	1012		10g. Citizen of What C	ountry?
the Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2反 Married  3 □ Widowed 4 □ Divorced	12. Was Decedent Ever Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:		Was Decedent of I If Yes, specify Cub 1 ☐ Yes 2 ☑ No		Specify Yes or No into Rican, etc.)	- 14. Race - Am Black, Whi Specify:	erican Indian,
the Medical	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12) 12	lucation de completed) College (1-4or 5+)	(Give	dent's Usual Occul kind of work done DO NOT use retire dministra	during most of w d)		Anne Arun Public Sc	del County
stic event,	To Be C	17. Father's Name (First, Middle, Last) W.J. Rubins Wil	lliam Isaa	c Robbi	.ns	18. Mother's Na Ettie	ame (First, Middle, Robins Et	Maiden Sumame) tie Catherine	
other traumat		19a. Informant's Name/Relationship (7 David Dulin/Husk) 20a. Method of Disposition	oand	41	Church Ro	oad, Arno		er, City or Town, State, 21012  20c. Location - City or	
injury or		1 ☐ Burial 2 ☑ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify 21. Signature of Funeral Service) Licen	2		Crematory	7 07,	/07/2006	Baltimo	re, MD
1 6 8		23a. Parti. Enter the disease, or comp	Dications that caused the	7.	95 GOV. F	credite i	wy, seve	erna Park Fi erna Park, I	Approximate
ician dical niner		shock, or heart failure. List only immediate Cause (Final disease or condition resulting in death)	a Due to (or as a co	all Cell onsequence of):	lung	cancel			Interval Between Onset and Death
ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a co	ensequence of):					
yalcaell all ne burial-tr		Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a co	insequence of):					
the attending priyation and iched for use as the burial-transit	cai	that initiated events	c. Due to (or as a co	regnancy ] Fetal death 3 [	□Ectopic pregnanc	у		23d. Date of de Month	olivery Day Year
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			1 - For State Registrar	State of	Marylar	nd / Depa	artmeni rtificate			and M		gien	2000	23360
- 2	Karalan da	2	Decedent's Name (First, Middle, La	st)				-			2. Date of De	ath		3. Time of Death
П	Physici		Hubert Gene	E1dr	idge						July :		2006 Year	11:45 p <sup>M</sup>
	/Medic Examir		4a. Facility Name (If not institution, giv				4b. City,	Town, or	Location o	f Death			c. County of Death	
4 4			National Naval M	edical C	enter		Betl	hesd	a			1	Montgomer	У
	Funeral		Social Security Number 6.3		. Age (In yrs.	last birthday)	If Under Months	1 Year Days	If Under 2 Hours	24 Hrs. Min.	8. Date of Bir (Month, Da			place (State or Foreign intry)
ш	Director		405-28-3904	IMM 2□F	79	Yrs.	WOITERS	Days	110013	IVIIII.	April 2	8,	1927 Ohi	
	pue M		Usual Residence of Decedent  10a. State 10b. County		10c Ci	ity, Town or Lo	cation							10d. Inside City Limits
	f sho	5	Virginia Fauquie	r		atlett	Cation							1 ☐ Yes 2√ No
	28a-	Director	10e. Street and Number	<u> </u>		attett	10f. Zip	Code			T	10- 0	Citizen of What Cou	**
	with with	₫	9668 Elk Run Road	-l			101. 2.15		119-2	121	,	-	ited Stat	•
	Jeath Tris 20	Funeral	11. Marital Status	12. Was Deced	lent Ever in U	J.S. 13. \	Was Deced				cify Yes or No		14. Race - Ameri	
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ည	be filed within 72 hours atter death with the Maryland ital Hygiene. Id other then "naturel", or Items 23a or 28a-f ehow event, Ite Mudicul Exattlest must be notified at	Completed	15. Decedent's E (Specify only highest gra	ducation		16a. Deced	ient's Usua kind of wor	Occupa	ition	of working	a		Kind of Business/Ir	ndustry
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2	ygier ygier tt,	Co		4		Chief	Execu	ıtiv				1	ernation	al, Inc.
D L	2 should be filed within 72 hours atter death with the Marylan and Mental Hygiene. is marked other then "naturel", or Items 23a or 28a-f ehow eumatic event, It a Madigul Examinar must be notified at	Be	17. Father's Name (First, Middle, Last		D1 1* 1						(First, Middle	, Maide		
7	should and Menion a market	ဥ	Hubert		Eldrid				Flos				Burdin	
Baitimore, Maryland 21215-0036			19a. Informant's Name/Relationship (										or Town, State, Zip	,
- 0	1 and Health am 27 sther tr	1	Veve Eldridge / N	Vite	20b I	9668 Place of Dispo			Road,		Lett, \	-	ginia 201 Location - City or To	
و	Pages nent of the int: If the		1 Ø Burial 2 ☐ Cremation 3 €	Removal from S		cemetery, crer lingtor	natory or ot	her place			/2006			
	rtme rtant njury	1	4 □ Donation 5 □ Other (Special 21. Signature of Funeral Service Lice			Nationa	l Cen	neter	CV I		2006	ALI	ington,	virginia
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н			shock, or heart failure. List only Immediate Cause (Final	one cause on ea	ch line.			, o. ajş	, 040. 40 .		Toophiatory a	11000		Interval Between Onset and Death
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8760	cate be executed physician and the burial-transit	dical		d										
Ö X	death certific e attending p id for use as	Mec	IF FEMALE:	20. 1/								- 1		
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o.	0 0	Physician/Me	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknov	nt at time of o	death 5∟	Other (spe	эспу)						,
J.	that ed by deta	4	Part II. Other significant conditions of	ontributing to dea	th but not res	sulting in the ur	ndertying ca	iuse give	n in Part I.		23e. Did to	obacco	use contribute to the	he cause of death?
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ဝ္ပ	> 43 0	Completed									24a. Was	an	24b. Were auto	psy findings available
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<u>g</u>	lcian: Th certificete ector, pag	a	25. Was case referred to medical			11.0			26. Place	of Death	1 Yes	2∭X N nel	o 1 Yes	2 <b>]</b> ∑ No
0 <	Physician: this certific ral director,	To B	examiner? 1 ☐ Yes 2 📉 No	Hospital: 1 🛣 Inj	patient 2	ER/Outpatien	3 DO	A Othe					6 ☐Other (Specif	iy)
	ding Pl h. After th funeral		27. Manner of Death 1 X Natural 5 ☐ Pending	28a. Date of (Month)	Injury Day Year)	28b. Time of Injury	28	Bc. Injury Work	at	2	d. Describe l	now inju	ury occurred	
<u> </u>	eat or: he	catl	2 Accident investigation 3 Suicide 6 Could not b				М	1 🗆 Y	es 2 N	10				
DIVISION	i Ditte	Certification;	4 Homicide determined	28e. Place o	f Injury - At h g, etc. <i>(Speci</i> i	ome, farm, stre fy)	et, factory,	office		2	3f. Location (S City or Tov	Street a vn, Stal	and Number or Rura te)	al Route Number,
	Hospital 24 hours e Funeral i		29a. Certifier 1X Certifying Ph	vsician: To the h	sect of my kno	wiedon doath		the time	a data and	d place of	ed due to the		s) and manner as s	
	To the Hos within 24 h To the Fur completely	Medical	(Check only 2 Medical Examone)	niner: On the bas and manne	is of examina	ation and/or inv	estigation,	in my op	inion, death	h occurre	at the time,	date ar	nd place, and due to	tated. the cause(s)
	To the within 2 To the E Complete	Me	29b. Signature and title of certifier				29c.	License	number			29d. D	ate signed (Month,	Day, Year)
0	HI		XXX		'>		01	0123	9146	(VA)		Ju1	y 10, 200	06
U	611		30. Name and address of person who	completed cause	of death (Iter	m 23a) (Type,					Medica	-		
			Suneil R. Ramchar				Ве				889-56			
	Sta Registr	-	31. Date filed (Month, Day, Year) <b>JUL 1 1</b> 20	32 Reg	gistrar's Signa	ature	100 B							
200	regioti		OOF II	JUU JU	190 /	100	4							

			1 - For State Registrar	State of Maryland /		artment of H			giene Reg. No.	006	23361
			1. Decedent's Name (First, Middle, Last,					2. Date of De	ath Day	Yeer	3. Time of Death
	Physici /Medio		Patricia	Lawrence		Foley		July 8,		7 001	9:42 A M
	Examin		4a. Facility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Death	•	4c. Co	ounty of Death	
	Funeral Director		3/ <del>9-</del> 0/ <del>-</del> 8848		birthday) Yrs.	Clint  If Under 1 Year  Months Days	Of If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da 02/12/19	th y, Year)		eorge's  place (State or Foreign  nty)  ington, DC
	pua *		Usuel Residence of Decedent  10a. State 10b. County	10c. City, To	own or Lo	cation					10d, Inside City Limits
	daryli f eho	ō	Maryland Prince Geo		er Mar						1 ☐ Yes 2√∑No
	the 28a	Director	10e. Street and Number	0 11		10f. Zip Code			10g. Citizer	n of What Cou	ntry?
	3a or		5714 Kenfield Lane			201	772.			USA	
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Deparmient of Health and Mental Hygiene. Disportment of Health and Mental Hygiene. Important: if Item 27 is marked other then "natural", or Items 23s or 28s-f show any njury or other traumatic event, the Medical Examinar must be notified at another.	by Funeral	11. Marital Status  1 Never Married 2 Married  3 Widowed 4 Divorced	12. Was Decedent Ever in U.S. Armed Forces? 1 □ Yes 2 页故o If Yes, Give Year or Dates:	1		ispanic Origin? (Sp in, Mexican, Puerto Specify:	pecify Yes or No Rican, etc.)		Race - Ameri Black, White,	
9	72 ho	Completed by	15. Decedent's Edu (Specify only highest grad			lent's Usual Occup	ation during most of work	cina	16b. Kind	of Business/Ir	ndustry
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ano	i be fi	Be	17. Father's Name (First, Middle, Last)  Lester Albright	Larmonaa			18. Mother's Nam Hetty	Cecilia	Greer	,	
Ž	d Me d Me mark matic	၉	Lester Albright  19a. Informant's Name/Relationship (Ty		9h Mailin	a Address (Street	and Number or Rui				n Codel
<b>∑</b>	id 2 s ith an 27 ie 1 trau		Kenneth Foley Jr. / S	Son							
ď,	Health tem 27 other tr		20a. Method of Disposition	20b, Place	of Dispo	enfield Lar sition (Name of	1. 1	erlboro, Date	20c. Locat	tion - City or To	
<u>o</u>	ages ant of it: if i		1 ☐ Burial 2 ☐ Premation 3 ☐ F 4 ☐ Donation 5 ☐ Other (Specify)	iemoval from State	s Cren	natory or other plac	<sup>e)</sup> July	11,200	Fdogue	ater, Man	rwland
Baltimore, Maryland 21215-0036	permit. P Depertme Importan any njur		21. Signatur uneral Service Licens				ss of Facility Geo Hill Road C	rge P. Ka xon Hill,			
			23a. Part 1. Enter the disease, or complishock, or heart failure. List only or	cations that caused the death. D							Approximate Interval Between
ı.	Physician		Immediate Cause (Final disease or condition		ON	DMEHMON	ТЛ				Onset and Death
	/Medical		resulting in death)	A SPIRATI  Due to (or as a consequence		F NEUMON.	L A				unknown
u	Examiner		Sequentially list conditions	UROSEPSI	S						unknown
	n =	ner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a consequence							
	acute ind trans	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	2.							
Ö,	oe exe	ũ	resulting in death) cast	Due to (or as a consequence	ce of):						
8760,	cate be executed physicien and the buriai-transit	dical		1.						-	
O. Box 6	that the death certificated by the attending point of the detached for use as	by Physician/Me	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcome of pregnancy 1 Live birth 2 Fetel dea 4 Pregnant at time of death 9 Unknown		Ectopic pregnancy Other (specify)			23d	. Date of delive	ery Day Year
₽.	res that t igned by be detac	'Ph	Part II. Other significant conditions cor	ntributing to death but not resulting	g in the ur	nderlying cause give	en in Part I.	23e. Did to	obacco use	contribute to t	he cause of death?
g	8 6 8	d b						10	res 2□N	lo 3 ☐ Prot	oably 4 Unknown
Ö	w requir been si should	Completed						24a. Was	an 2	4h Were auto	opsy findings available
Ä	The lay cete hes page 2	ᇤ						autor perfo	rmed?	prior to co death?	mptetion of cause of
ta		ပိ	25. Was case referred to medical				26. Pface of Deat	1 Yes	2□No	1 🗆 Yes	XK No
<u>=</u>	ysicii s cer direct	To B	examiner? 1 \( \sum \) Yes 2\( \sum \) No	lospital: Inpatient 2 ER/	Outpatien	t 3 DOA Othe	25	ome 5 Resid		Other (Specia	(v)
Division of Vital Records,	Attending Physicien: r death. sctor: Atter this certific by the funeral director.		27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	1 00	o. Time of Injury	28c. fnjun Worl		28d. Describe			,,
Divis	5 th 15 c	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, building, etc. (Specify)	farm, stre	eet, factory, office		28f. Location (S City or Tox		lumber or Rura	al Route Number,
	To the Hospital or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely filled in by the funeral director.	Medical (	29a. Certifier 1 Certifying Phy (Check only one) 1 Medical Exami	sician: To the best of my knowled ner: On the basis of examination and manner stated.	ige, death and/or inv	occurred at the tin restigation, in my o	ne, date and place, pinion, death occur	and due to the red at the time,	cause(s) and date and pla	d manner as s	stated. o the cause(s)
	To the To the comp	Σ	29b. Signature and title of certifier			29c. License		- 1		igned (Month,	Day, Year)
	(20)		1 / Emit	Tank M.	P.	D 939	996		07/09/2	2006	
	90		30. Name and address of person who co Rointan Farahi—Far				341 Silver	Spring,	Marylan	nd 20902	2
×	Sta Registr		JUL 1 2 2006	32. Registrar's Signature							

		ŀ	1 - For State Registrar	State of	Maryland / D	-	tment of H				giene Reg. No.	006	233	62
7			Decedent's Name (First, Middle	e, Last)						2. Date of De			3. Time of De	eath
	Physici		Rosella M. Fo	bro						July	05	2006	0900	М
Sec.	/Medic Examin		4a. Facility Name (If not institution		oer)		4b. City, Town, or	Location	of Death	Dury		inty of Death		
	Examili	E	2002 A Rudy				Eldersbu	ıra			Carr	011		
	Funeral	***	5. Social Security Number		. Age (In yrs. last birt	thday)	If Under 1 Year	If Under		8. Date of Bir	th	9. Birth	nplace (State or F	Foreign
(K.,	Director		213-20-0698	1 ☐ M 2 💢 F	80	Yrs.	Months Days	Hours	Min.	May 19	у, Year) • 1926	Col	intry) MT	
	ס		Usual Residence of Decedent		11									
	nylan how		10a. State 10b. County		10c. City, Town	or Loca	ation						10d. Inside City	
	Ma-f-8	cto	MD Ca	arroll	E	lder	sburg						1 □ Yes 2	X No
	or 28	Oire	10e. Street and Number				10f. Zip Code				10g. Citizen	of What Co	untry?	
	23e	Funeral Director	2002 A Rudy	Serra Driv	<i>r</i> e		2.	1784				USA		
	ams ams	nei	11. Marital Status	12. Was Deced Armed Ford	ent Ever in U.S. es?	13. Wa	as Decedent of Hi Yes, specify Cuba	ispanic Or	gin? (Sp	ecify Yes or No Rican, etc.)	14. [	Race - Amei Black, White		
98	or Itams		1 Never Married 2 Marr	If Yes, Give			⊒Yes 252 No	Specify:					White	
21215-0036	be filed within 72 hours after death with the Maryland ital Hyglene. Id other then "naturel", or Itams 23e or 28e-f show event, Ita Mudical Exatr, ner must be motified at	d by	3 X Widowed 4 □ Divorced											
Ϋ́	"nat	Completed		t's Education st grade completed)	16a.	(Give kil	int's Usual Occupa ind of work done o O NOT use retired	during mos	t of work	ing	16b. Kind o	f Business/l	ndustry	
12	within ene. then "	E D	Elementary/Secondary (0-12)	College (1-4				,	Tna	noatox	m <sub>o</sub> 1	omo as:	ni	
	e filed within al Hygiene. I other then '		17. Father's Name (First, Middle,	( ast)	Ω	uall	ity Assur			e (First, Middle,		emeca:	nique	
ano	ntal I	Be	Charles E. Mu							. Knous		,		
2	should be nd Menta r marked umatic ev	ဥ	19a. Informant's Name/Relations		19h	Mailing	Address (Street a					wn State 7	in Code)	
Maryland	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		Sterling E. Fo				Deer Parl						,,,	
	s 1 an if Heal item 2 other		20a. Method of Disposition		20b. Place of	Disposit	tion (Name of atory or other place		07/0	872006	20c. Location	on - City or 1	Town, State	
0	00		1 Surial 2 Cremation		ale		atory or other place [Memoria	1			Fin	lechur	~ MD	
Baltimore,	# 문 <b>원</b> 등 .		4 □Donation 5 □ Other (S 21. Signature of Funeral Service		Evergr							ksbur		_
Ba	Department Department of the popular p		1/2010 1			F	Name and Address	inera	1 Ho	me and	Chapel	., P.A	•	
20			23a Part 1 Enter the disease of	complications that cal	used the death. Do n	not enter	12 Washi	ingto	n Ro	ad Wes	tminst	er, M	D 21157 Approximate	
1			23a Part 1. Enter he disease, or shock, or heart failure. List Immediate Cause (Final	only one cause on ea	ch line.	: _	_ ^/					A II.	Interval Betwee	
K-	Physician /Medical		disease or condition resulting in death)	a. M	elostal	L	Suall	al		arches	mop	PILVE	3mos	<u>,                                      </u>
42	Examiner			Due to (o	r as a consequence	OT):	Omes	R	M	0.	_	7		
		ē	Sequentially list conditions, if any, leading to immediate	b. Due to (o	r as a consequence of	of):	Jem (	) 10						
	nsit	Examine	cause. Enter Underlying	<	C									
~	be executed icien and burial-transit	Exa	that initiated events resulting in death) Last	c. Due to (o	r as a consequence of	of):								
8760,	ate be executed hysicien and the burial-transit	cal		d										
9	ificat g phy as th	P												_
Вох	eath certific attending p	2	IF FEMALE: 23b. Was decedent pregnant		ome of pregnancy	2 Or					23d.	Date of deli	v <i>e</i> ry	
-	death certifica e attending ph ed for use as t	cia	in the past 12 months? 1 ☐ Yes 2 ☐ No	4 □ Pregna	th 2 Fetaf death nt at time of death		Ectopic pregnancy Other (specify)					Month	Day Yea	ar
0		Physician/M	9 🗆 Unknown	9□ Unknov	vn									
	The law requires thet the ste has been signed by th bage 2 should be detache	by P	Part II. Other significant condition	ons contributing to dea	th but not resulting in	the und	derlying cause give	en in Part I	4	The state of the s		contribute to	the cause of dea	ith?
ğ	w require been sig should b		Huge	1 tendro	N L	less	Her Cll	بالكلال	Kla	Denge 1 de	Yes 2□N	o 3 □ Pro	obably 4 Duni	known
Records,	as been 2 shoul	piet			7		N			24a. Was		b. Were au	topsy findings av	ailable
	The lay	Completed								autor perfo		death? 1 ☐ Yes	2□ No	58 OI
Vital		0	25. Was case referred to medica	1			~	26. Place	of Deat	h (Check only o				
>	ysic is ce direc	To B	examiner? 1 ☐ Yes 2 ☑ No	Hospitaf: 1   In	patient 2 ER/Ou	tpatient	3□ DOA Othe	er: 4□Nu	ursing Ho	me 5 Resi	dence 6 □	Other (Spec	ufy)	
J Of			27. Mannar of Death 1 ■ Natural 5 □ Pendir	28a. Date of (Month	Injury 28b. T Day Year) II	Time of	28c. Injury Work	y at k?		28d. Describe	how injury oc	curred		
0	Attending or death.	atic	2 Accident investi	gation				Yes 2□	No					
Division	r Att	Certification:	3 ☐ Suicide 6 ☐ Could 4 ☐ Homicide delam	lined 289. Place C	f fnjury - At home, fa g, etc. (Specify)	rm, stree	et, lactory, office			281. Location (. City or Tox	Street and Nu wn, State)	imber or Ru	ral Route Numbe	₽ſ,
	Itel or irs afte rel Dir led in													
	Hospitel	edical	(Check only 2 Medical	ng Physician: To the b Examiner: On the bas	is of examination and	, death o d/or inve	occurred at the timestigation, in my or	ne, date ar pinion, dea	nd place, ath occur	and due to the red at the time.	cause(s) and date and place	manner as	stated. to the cause(s)	
	the the the	Med	one)	and manne	er stated.		29c. License			-				
			29b. Signature and title of certifie	1 Lon	нD		200,150	29	15		29d. Date sig		, Day, 10di)	
	MIL		- Funda	MM				ا ا ا	U		1/4	100	7	
	15		30. Name and address of person	who completed cause	of death (ftem 23a) (			1	La	1401	71111	lo. A.	0 2115	7
			31. Date filed (Month, Day, Year,	1	strar's Signature	, S.	HONER	् गर	الل	veet	mus	4	D < 11/2	1
44	Sta Registi		1111 1	0 2006	Page - K	A	hands .							
E.			00L 1	2 5000	MANAN YO.	19								

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. . Decedent's Name (First, Middle, Last) 2 Date of Death Day Year Physician July 3, 2006 Edward Gaston 8:53 P. M James /Medical Facility Name (If not institution, give street and number)

Thomas More Nursing and 4b City Town or Location of Death 4c. County of Death Examiner Prince Georges Rehabilitation Center Hyattsville If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 1928 | 9. Birthplace (State or Foreign (Month, Day, Year) | 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**X**M 2□ F Months Days 77 Yrs. 242-36-2247 November 30, North Carolina Director Usual Residence of Decedent the Maryland 10c. City. Town or Location 10a State 10h County 10d. Inside City Limits 28a-f show the Madical Examiner must be notified at 1 Yes 2 □ No Directo District of Columbia Washington 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ö 20012 722 Tewkesbury Place, N. W. United States Itema 23a Funeral 12. Was Decedent Ever in U.S. Armed Forces? Nov.1952 Infes, Give Year or Dates: Oct.1954 14. Race - American Indian, Black, White, etc. 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 ŏ 1 ☐ Yes 2 X No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Oct.1954 "natural", Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) National Institutes e filed within al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) of Health 12th grade Medical Technician 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) permit. Pages 1 and 2 should be file Department of Health and Mental Hy important: if Item 27 is marked oth any injury or other traumatic event 9DEs. Be Vance Gaston Dora Hambrick 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Ruth Bernice Waddy Gaston (Wife) 722 Tewkesbury Place, N.W.; Washington, D.C. 20012 July 13,2006 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1X Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Ouantico National Cemetery Quantico, Virginia R. N. Horton Company Morticians, Inc. 21. Signature of Funeral Service Vicensi 600 Kennedy Street, N.W.; Washington, D.C. 20011 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) HRTERIOSCIENATU GADIOVASCULAR DISEASE
Due to (or as a consequence of): **Physician** 4-eans /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner ed by the attending physician and detached for use as the burial-transit the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physiclan/Medicai IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Day 4☐Pregnant at time of death 5 Other (specify) 1 Yes 2 No 9 Unknown 9 Unknown signed by to Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Failore 1 Yes 2 No 3 Probably 4 onknown Completed peeu 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy performed? 2 No 1□ Yes 2**X** No 1 Yes or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4X Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2X No 1 Inpatient ٩ 2 ER/Outpatient 3 DOA After this funeral of 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending within 24 hours after death.
To the Funeral Director: Af 1 ☐ Yes 2 ☐ No investigation 2 Accident 3 ☐ Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) illed in by 4 Homicide ro the Hospitai 29a. Certifier 🛣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) , 2006 July 💪 0060100 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20903 Tahmina K. Ahmed, M.D.; 831 University Blvd. East; Suite 27; Silver Spring, Maryland 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 11

DHMH 17 Rev 1/2001

Registrar

2006

State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Month Day **Physician** INDIANA JULY 8 2006 4:20 A /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** PRINCE GEORGE'S FT. WASHINGTON FT. WASHINGTON HEALTH & REHAB CENTER 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 9. Birthplace (State or Foreign 8. Date of Birth (Month, Day, Year) FEB • 27 1916 5. Social Security Number **Funeral** Months Days Hours 1 ☐ M 2 🖾 F GEORGIA Yrs. 90 073-20-6152 Director Usual Residence of Decedent 10d, Inside City Limits 10a. State 10b. County 10c. City. Town or Location or 28a-f show r than "natural", or items 23a or 28a-f sho the Medical Examiner must be notified at WASHINGTON 1 Yes 2 □ No FT. PRINCE GEORGE'S Director MD 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20744 805 WEST TANTALLON DRIVE U.S.A. death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ ☐No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: þ **BLACK** 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) MANAGER PRIVATE 2 yrs other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 end 2 should be file Department of Heelth and Mental Hy Important: If Itan 27 is marked oth any lighty or other traumatic event popes. Be HATTIE MAE GLENN JOHNSON WAYMON 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 805 WEST TANTALLON DRIVE FT. WASHINGTON, MARYLAND JACQUELINE GALES WEBB/DAUGHTER 20744 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Surial 2 Cremation 3 Removal from State 7/18/2006 AMITIVILLE, NEW YORK PINE LAWN CEMETERY 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** ATHEROSCLEROTIC CARDIOVASCULAR DISEASE /Medical Due to (or as a consequence of): Examiner Sacuentially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner Hospital or Attanding Phyaician: The law requires thet the death certificate be executed the burial-transit end Due to (or as a consequence of): Box 68760. physicien Physician/Medical 98 esn. IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant 2 Fetal death 3 Ectopic pregnancy ŏ in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐Pregnant at time of death 5 Other (specify) P.0. 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ۵ Records, cete hes been sig, page 2 should b 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Be Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy 1 Yes 2 2 No 1 🗆 Yes 2X No Division of Vital 25. Was case referred to medical 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐XNo Certification; To 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation within 24 hours after death. To the Funeral Director: A 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) δ 4 - Homicide filled in 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical To the Fun completely t (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 87-19 -2006 D45365 711 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3 MICHAEL SIDAROUS M.D. 11701 LIVINGSTON ROAD # 101 FT. WASHINGTON, MARYLAND 20744 32. Registrar's Signature 31. Date filed (Month, Day, Year) 1 1 2006 Registrar

### 06-04799

Kelvin Demetrius Gilchrist

# Please Type or Print in Black Indelible Ink

State of Maryland	Department of Health	and Mental Hygiene
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		1- For State Registrar	Certificat	te of Deat	h	R	eg No.	106 2336
Physici		Decedent's Name (First, Middle,Last)				Date of Dea     Month	Day Year	3 Time of Death 0848 hrs
Medical Exami	ner	Kelvin Demetrius G  4a. Facility Name (if not institution, give street and numb	ilchrist	Ab City 1	Town, or Location of	July 7, 20	4c. County of	
		Prince Georges Hospital	er)	Chev		or Death	Prince Ge	
Funeral		5. Social Security Number 6. Sex 7.	Age (In yrs. last birthd	lay) If Und	er 1 Year If Unde	er 24Hrs 8. Date of Bi	rth (MM/DD/YYYY)	9 Birthplace (State or
Director		577-02-4274 1XM 2_F	35	Yrs. Month	s Days Hours	Min. Sept.	27,1970	Foreign Country) DC
		Usual Residence of Decedent		110.		Joseph		
any		10a State 10b. County	10c. City, Town or	Location				10d Inside City Limits
Maryland 28a-f show datonce.	5	Maryland Prince George	Laurel					1 X Yes 2 No
Maryl 28a-f d at o	Director	10e. Street and Number	•	10f. Zip	Code	1	0g. Citizen of Wha	it Country?
death with the Maryland or items 23a or 28a-f sho	₫	14928 Cherrywood Drive		207			United St	ates
th with	Funeral	11. Marital Status 1 Never Married 2 X Married Armed Force				gin? (Specify Yes or No Puerto Rican, etc.)	- 14. Race - White,	American Indian, 8lack, etc.
er dear	Ē	1 Yes	2X No	4 N 0			0	Black
15-0036 filed within 72 hours after Hygiene ed other than "natural", o t, the Medical Examiner.	ģ	Widowed 4 Divorced If Yes, Give Year or Dates:  15. Decedent's Education (Specify only highest grade or Dates)	completed) 16a De		X No specify: Occupation (Give I	kind of work done	Specify: 16b. Kind of Bus	
2 hou "nat	ompleted	Elementary/Secondary (0-12) College (1-4	du		king life. DO NOT			,
036 thin 7 ne • than ledica	ם	12	Cus	stomer S	Service E	ngineer	Private	2
5-0( led wi Hygie other	ပ၂	17. Father's Name (First, Middle, Last)	•		18 Mother	's Name (First, Middle,	Maiden Surname)	
<b>21215-0036</b> Mottal Hygiene market of the Maryland Mental Hygiene market other than "natural", or items 23a or 28a-f shoir event, the Medical Examiner must be notified at once.	Be	Tommy Gilchrist				ora Garre		
imore, MD 2121 Pages I and 2 should be fi men of Health and Mental nant: If item 27 is marked or other traumatic event,	유	19a Informant's Name/Relationship (Type, Print )				nber or Rural Route Nur		
timore, MD 2 t Pages 1 and 2 shou trent of Health and N rtant: If item 27 is n y or other traumatic		Deborah Gilchrist / Spou		Disposition (Nar		Drive Laur		City or Town, State
Baltimore, permit Pages I ar Department of Hee Important: If ite		1 X Burial 2 Cremation 3 Removal from	State crematory	y or other place)	)	= 1		
ti Pag ti Pag riment ritant		4 Donation 5 Other Specify  21. Signature of Funeral Service Licensee	Marylan	nd Natio	nal Cem.	7/14/06	Laurel,	Maryland
Baltimc permit Page Department Important: injury or ou		1 A + H   H   H   H   H   H   H   H   H   H		Alexand	ler S. Po	pe Funeral	Homes, H	P.A. aryland 20747
Physician	$\neg$	23a Part I Enter the disease, or complications that caus	sed the death. Do not e	enter the mode of	ATIDOTO P of dying, such as ca	'IKE FOREST' ardiac or respiratory arr	VILLE, Ma est, shock, or hear	t Approximate Interval
/Medical		Mallure List only one cause on each line  Immediate Cause (Final disease a Multiple Injuri	es					8etween Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  Due to (or as a co						
		Sequentially list conditions, b						
	ine	if any, leading to immediate cause. Enter Underlying Cause	nsequence of):					
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3760, ficate br g physic s the bur	Š	IF FEMALE: 23c. If yes, out 23b. Was decedent pregnant in the 1 Live birth	come of pregnancy	Fetal death	3 Ectopic	pregnancy	23d Date of d Month	elivery Day Year
Box 68 e death certif the attending	<u>Cia</u>	past 12 months?	t at time of death 5	Other (Spe		programoy	Wioniti	Day Tear
, P.O. Box 68 res that the death certif signed by the attending be detached for use as	hys	1 Yes 2 No 9 Unknown 9 Unknown						]
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Rec	E O					perfo 1 ✓ Yes		ath? ✓ Yes 2 No
tal Rections: The certificate ector, page	Be C	25. Was case referred to medical examiner?			26.Place of Death	(Check only one)		
Division of Vital Records, P.O. tall or Attending Physician: The law requires that the stater death.  **All Director: After this certificate has been signed by led in by the funeral director, page 2 should be detacted.	To E	1 ✓ Yes 2 No	atient 2 🗸 ER/Outp		OOA Other	Nursing Home 5	Residence 6	Other:
n of Jing Ph After t funeral		27. Manner of Death  1 Natural 5 Banding Jul 7, 2006	Injury 28b. Tin (19,Year) 0737 h		28c, Injury at Work	motorcyclic	how injury occurred collided wit	
ivisior or Attenc after death Director:	atic	2 Accident Investigation			1 Yes 2 🗸			
Divisior spital or Attent ours after death peral Director: filled in by the	Certification:	Suicide Could not be determined (Specify)	f Injury - At home, farm	n, street, tactory	, office building, etc	or Town, S	itate)	or Rural Route Number, City
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Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	Medical	(Check only one)  2  Medical Examiner: On the basis of e	examination and/or inve					
To With	Mec	29b. Signature and title of certifier	ed		c. License number	·		(Month, Day, Year)
5		Municity M. Uh.	li		O.C.M.E.		July 8, 2006	
		30 Name and address of person who completed cause	of death (Item 23a)				<u> </u>	
छ्यं		·	al Examiner 1	11 Penn Str	eet, Baltimore	e, MD 21201		
S	tate	31 Date find (10n 2005 Year)	trar's Sabetyre	-			-	
Regis	trar	JUL EDGO JACON						

06-04837 John Gebhardt

### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene

1- For State Certificate of Death Reg. No Registrar Decedent's Name (First, Middle, Last) 2. Date of Death Physician/ Month Day July 8, 2006 John Anthony Gebhardt 0448 hrs **Medical Examiner** 4b. City, Town, or Location of Death 4c. County of Death 4a Facility Name (if not institution, give street and number) Sinai Hospital **Baltimore** If Under 24Hrs 8. Date of Birth (MM/DD/YYYY) 9 Birthplace (State or 5. Social Security Number 7 Age (In yrs. last birthday) If Under 1 Year 6. Sex **Funeral** Foreign Maryland Country) Months Director 65 1941 213-38-8671 May 30, 1 X M 2 Usual Residence of Decedent 10d. Inside City Limits iny 10a. State 10b. County 10c. City. Town or Location Westminster Carroll 1 Yes 2 X No 28a-f show Maryland 10e. Street and Number 10f. Zip Code 10g Citizen of What Country? notified at 2026 Frizzellburg Road 21158 USA 23a Funeral 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( Specify Yes or No-14. Race - American Indian, Black Armed Forces' If Yes, specify Cuban, Mexican, Puerto Rican, etc. White, etc. 1 Never Married 2 Married white 1 XYes f Yes, Give 1959-1967 or Dates: 1959-1967 1 Yes 2 X No specify Specify Widowed Divorced "natural", þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed Elementary/Secondary (0-12) College (1-4 or 5+) mit Pages I and 2 should be filed within 72 I ppartment of Health and Mental Hygiene portant: If item 27 is marked other than "I jury or other traumatic event, the Medical E Driving Instructor Driving Academy Baltimore, MD 21215-0036 12 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) John C. Gebhardt Catherine Steck Be 19a. Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2026 Frizzellburg Road, Westminster, MD 21158 Lynne Gebhardt, wife 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 079°†°1 crematory or other place) Burial 2 X Cremation 3 Removal from State Winfield, MD 2006 South Carroll Crematory Donation 5 Other Specify 22. Name and Address of Facility Signature of Funeral Service Licenses M01191 Myers-Durboraw Funeral Home 91 Willis Street, Westminster, MD 21157 Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or Approximate Interval Physician ailure. List only one cause on each line. Between Onset and /Medical Death a Multiple Injuries Immediate Cause (Final disease xaminer or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions, Due to (or as a consequence of): Examiner if any, leading to immediate cause. Enter Underlying Cause (Discass or injury that initiated events resulting in death) Last Due to (or as a consequence of): and cal 28f per M.E. 07/12/2006 Carroll County, wj1 UNPENDED X AMENDED sician ian/Medi Box 68760, 23c. If yes, outcome of pregnancy IF FEMALE phy: the b 23b. Was decedent pregnant in the 3 Ectopic pregnancy Month Day Year Live birth Fetal death 2 past 12 months? Pregnant at time of death 5 Other (Specify) Yes 2 No 9 Unknown 9 Unknown Phy detached 23e Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Division of Vital Records, P.O. ğ Yes 2 V No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available prior to completion of cause of autopsy performed? death? Yes 2 1 🗸 Yes No certificate page the Hospital or Attending Physiciau: To 24 hours after death

re Funeral Director: After this certifical letely filled in by the funeral director, p 26 Place of Death (Check only one) 25. Was case referred to medical Be examiner? Hospital: 1 Inpatient Other | ER/Outpatient 3 DOA Nursing Home 5 Residence 6 1 V Yes No 28a Date of Injury (Month Day Year) Jun 27, 2006 28d Describe how injury occurred 28b. Time of Injury 28c. Injury at Work 27. Manner of Death Certification: Passenger auto auto collision 0945 hrs 1 Natural 5 Pending 1 ✓ Yes 2 No 2 🗸 Accident Investigation Rt. of rough Street and Number of Rural Route Number City
Rt. of rough Street and Number of Rd. Westminster 28e. Place of Injury - At home, farm, street, factory, office building, etc 3 Could not be Suicide determined (Specify) Local Street Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started (Check only Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the I To the and manner stated 29c. License number 29d Date signed (Month, Day, Year) 29b Signature and title of certifier MSZ O.C.M.E. July 9, 2006 AVITOS Mone 30. Name and addr as of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Margarita Korell MD. Assistant Medical Examiner 31. Date filed (Month, Day, Year) Registrar

			For State Registrar		State of I	Maryland		artmen rtificate				lental H	ygien Reg. N	000	16	23367
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	Funoral		Suburban Hosp  5. Social Security Number	6. Sex		Age (In yrs. la	st birthday)	If Under		If Under		8. Date of E	Birth	Montg	9. Birthp	lace (State or Foreign
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36	i within 72 hours after death with the Maryland liene. r then "neturel", or Items 23a or 28a-f show the Medical Examinat must be notified at	by Fu	1 ☐ Never Married 2 ☑ Mar 3 ☐ Widowed 4 ☐ Divorced		1 X Yes 2 If Yes, Give	□ No	1	1□Yes 2		Specify:		,		Specify:		nite
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Baltimore,	permit. Pag Department Important; i any injury o		21. Signature of Femeral Service	Lice se	9e		T (	2. Name an	d Addres	s of Facili	ty	uneral				
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Вох	attend for us	slan	23b. Was decedent pregnant in the past 12 months?	-		2 Fetal of tat time of dea	death 3[	Ectopic pro						23d. Date Month		ory Day Year
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	ding I h. After funer	tlon	27. Manner of Death  1 Natural 5 Pendir 2 Accident investi		28a. Date of I (Month,	Day Year)	Injury	M M	8c. Injury Work	rai ⟨? Yes 2		28d. Describ	a now inj	ury occurred	1	
Division	spital or Attending Phous after death. Ieral Director: After th	Certification;	3 ☐ Suicide 6 ☐ Could	not be	28e. Place of	Injury - At hon	ne, farm, st								or Rura	l Route Number,
ğ	al or A s after il Direct	erti	4  Homicide	iiiiou	building	, etc. (Specify)					Į.	City or I	own, Sta	ite)		
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			30. Name and address of person	who co	mpleted cause	of death (Item)	23а) (Туре,	Pripri)	Barba	ara K	alaz	ny, M.	11/1	21	De	52
			0103 HUI	11/	WUJ C	1 Well	7/1/	mer	R C	116	-06	// /		20	0,	_
	Sta Registi		31. Date filed (Month, Day, Year, JUL 1 1	200	06	istrar's Signatu	ire do	who								

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1 Decedent's Name (First, Middle, Lest) 2. Date of Death 3. Time of Death Day Year Month **Physician** DORIS **GREGG** HOLSTON JULY 2006 1:56 PM /Medical 4b. City, Town, or Location of Death 4c. County of Death 4e. Facility Name (If not institution, give street and number) Examiner Sandy Spring Montgomery Brooke Grove Rehabilitation-Nursing Center 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Hours 1□M 2XF 213-24-3232 Maryland Director Dec. 16 1927 Usual Residence of Decedent 10a. State 10c. City. Town or Location 10d. Inside City Limits 10b. County rel', or items 23e or 28e-f shov Examiner must be notified at 1 ☐ Yes 2 No Derwood Md. Montgomery Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 20855 United States 18101 Bowie Mill Road Funerai 12. Was Decedent Ever in U,S. Armed Forces? 1 ☐ Yes 2 XNo If Yes, Give 14. Race - American Indian, 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. 1 Never Married 2 Married White If Yes, Give Year or Dates: 1 ☐ Yes 2 ☐ No Specify: ð Specify: 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grede completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12  $\cap$ 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Department of Health and Mental H
Important: If item 27 is marked of
eny Injury or other treumatic eve
once. Marie Louise Beall Charles Franklin Gregg, Sr. P 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 18101 Bowie Mill Road, Derwood, Md. William E. Holston / Husband 20855 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐ Removal from State Union Cemetery 7/12/06 Burtonsville, Md. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 22. Name and Address of Facility
Muriel H. Barber Funeral Home much P. O. Box 5038, Laytonsville, Md. 20882 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death **Physician** Immediate Cause (Final disease or condition resulting in death) Pheomonia /Medical days Examiner Physician/Medical Examiner To the Hospital or Attending Physicien: The law requires that the death certificate be executed within 24 hours after death.

To the Funerel Director: After this certificate hes been signed by the attending physician and completely filled in by the funeral director, page 2 should be deteched for use as the buriel-transit Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Due to (or as a consequence of): Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobecco use contribute to the cause of deeth? 1 Yes 2 No 3 Probably 4 Unknown heart failure à 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? Completed 1 Yes 20 No ti You of No 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Be Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: Nursing Home 5 Residence 6 Other (Specify) 1 Yes 20 No Certification: To 27. Manner of Death 28d. Describe how injury occurred 28b. Time of 28c. Injury at Work? 1 Natural 2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No 6 ☐ Could not be determined 3 Suicide 28f. Location (Street end Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as steted.

2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the ceuse(s) and manner stated. Medicai 29a. Certifier (Check only 29d. Date signed (Month, Day, Year) 29b. Signature end title of certif 29c. License number hysicias D0055694 2006 30. Name and eddress of person who completed cause of death (Item 23a) (Type, Print) Olvey, MD 108 ALUK 4000 MATHUR 32. gistrar's Signeture 31. Date filed (Month, Day, Year)

State

Registrar

2006

JUL

**DHMH 16 Rev 6/95** 

the Maryland

Pages 1 and 2 should be filed within 72 hours after death with

and Mental Hygiene.

Baltimore, Maryland 21215-0020

Division of Vital Records, P.O. Box 68760.

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# Danald Chamber Hur Baltimore, Maryland 21215-0036

Physician Medical Examiner    Common   Chambers   County of Death			For State Registrar	Plea			t <b>in Black Ir</b> ryland / Dep <i>Ce</i>		of Hea	alth and I	_		ne	2226
Doctor's Community Bospital  S. Social Security Purpose  S		144	1. Decedent's Nan  Donald	Chambe	rs Hart						July	Death	Day Year	3. Time of Death 6 7:14 f
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Cassandra Jones / Fiancee' 4617 Quinby Ave. Beltsville, MD 20705  20a. Method of Disposition   20b. Place of Disposition (Name of Passa)   20b. Place of D	arked other atic event, I	Be	17. Father's Name		•							lle, Maide	en Sumame)	
1 Septence   1 S	27 ls r trau		Cassand	ra Jone			4617	Quinb	y Ave		sville,	, MD	20705	
Shock, or heart faulur. List only onlycuse on each line.  Immodate Cause (Final death)  Sequentially ist conditions, of any, leading to immodate cause. Ener Underlying or substantial death and the conditions of any, leading to immodate cause. Ener Underlying or substantial death and the conditions of any, leading to immodate cause. Ener Underlying or substantial death and the conditions of any, leading to immodate cause. Ener Underlying in death)  Sequentially ist conditions, of any, leading to immodate cause. Ener Underlying or substantial death and the conditions or substantial death and the condi	tant: If		1 😾 Burial 2 4 🗆 Donation 21. Signature of F	Cremation 5 Other (Suneral Service	Specify) Licensee	Max	Lincoln  7	Memoria 22. Name and a 216 Ken	a1 Address onedy	Street	13,2006 nson ar NW Was	Sui nd Je shing	itland, i	MD uneral Hom 20011
The initiated events is sulfing in death) Last    Due to (or as a consequence of):   Due to (or as a consequence of to the least of time of the least of the	ledical		shock, or he Immediate Cause disease or condit resulting in death	art failure. List (Finat ion )	aDue	on each line	stage li							Onset and Death
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The state of the s	ate has page 2	Complet									au pe	topsy rformed?	prior to death?	completion of cause of
29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29a. Certifier  (Check only one)  29b. Leaves symbox  20c. Leaves symb	After this funeral di	To B	examiner? 1 Yes 2 2	No ath 5 □ Pendi	Hospital: 1			of 280	Other: . Injury at Work?	4 Nursing H	lome 5 Re	sidence		acity)
29a. Certifier (Check only one)  29b. Signature and title of certifier  29c. License number  29c. License number  29d. Date signed (Month, Day, Year)	ã.⊆			deter	ningd   288. P	lace of Injudual	ry - At home, farm, s (Specify)	treet, factory, o	office		28f. Location City or 1	(Street own, Sta	and Number or R ate)	lural Route Number,
D 43446 7/1/2	the Fune	Wedica	(Check only one)	2 Medical	Examiner: On the and r	he basis of	ed.	nvestigation, ir	my opin	on, death occu	irred at the tim	e, date a	and place, and du	e to the cause(s)
30. Name and address of person who completed cause of death (Item 23a) (Type, Print)	5		) R	it a				296. t	) 4 3	446		7/	16/06	un, vay, Irdij

State Registrar DHMH 17 Rev 1/2001

t.	• (		For	State of Maryla	nd / Depa	artme	nt of H	ealth a	nd M	ental Hy	giene		
A	mended	#	1- State Registrarl per phy o				ite of L				Reg. No.	1006	23370
	Physici	an	1. Decedent's Name (First, Middle, Las	sr)						2. Date of De Month	Day	Year	3. Time of Death
	/Medic	al	4a. Facility Name (If not institution, give	ctrost and number)		4b Cit	y, Town, or	Location of	Death	07	0B	County of Deat	11 10 AM
	Examin	er	LAVREL BELINAZ				AVZE		Doam				180846
· S	Funeral		5. Social Security Number 6. S	ex 7. Age (In yr	s. last birthday)	If Und	er 1 Year s Days	If Under 2	24 Hrs. Min.	8. Date of Bir (Month, Da	th		hplace (State or Foreign untry)
· 38	Director		214 35 9677 Usual Residence of Decedent	X <sup>M 2□F</sup> 57	Yrs.					AUG 2	26,	1948	S KOREA
	/land		10a. State 10b. County	10c. (	City, Town or Lo	ocation							10d. Inside City Limits
	h the Maryland rr 28a-f show	ctor	MD PRINCE	GEORGE L	AUREL								1 ☐ Yes 2 ☐ No
	vith th	Director	10e. Street and Number				Zip Code				_	zen of What Co	untry?
	eath with		8126 MALLARD  11. Marital Status	SHORE DR  12. Was Decedent Ever in	US 13		20724	snanic Orig	in? (Spe	offy Yes or No		SA 14. Race - Ame	rican Indian.
0	or Item	Funeral	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give A		If Yes, sp	ecify Cubai	n, Mexican,	Puerto F	Rican, etc.)		Black, White	e, etc.
5-0036	n 72 hours after death with the Maryland "natural", or Items 23a or 28a-f show palical Examinational be multified at	d by	3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		1 L Yes	2 No	Specify:				Specify: A	SIAN
7	n 72 h	Completed	15. Decedent's Ed (Specify only highest gra	ducation de completed)	(Give	kind of v	sual Occupa work done d use retired,	urina most	of workin	ig .	16b. Kir	nd of Business/	Industry
212	jene.	шо	Elementary/Secondary (0-12)	Coltege (1-4or 5+)	STO		MANA				PR:	IVATE	
2	sal Hygi d other	Bec	17. Father's Name (First, Middle, Last)							(First, Middle		Sumame)	
Maryland	d Menidan narken natica	2		HONG	405 14-15		/2	YO		HA	LEE	T C1-1-	Fo Control
<u>s</u>	s 1 and 2 should f Health and Mer Item 27 le marke other traumatic		19a. Informant's Name/Relationship (1 JAY HONG /	SON			ICKNE					Town, State, 2	20866
Ğ,			20a. Method of Disposition		Place of Dispo	osition (A	iame of	e)	D	ate	20c. Lo	cation - City or	Town, State
Ĕ	Page tment o tent: If ijury or		1 Burial 2 Cremation 3 4 Donation 5 Other (Speed)	ME ME	TROPO	LITA	N CR	EMAT(	ORY	7/11/	<b>6</b>	ALEX	VA
Baltimore,	permit. Page Department Importent: I eny injury o		21. Signature of Funeral Service Ucer	71			and Addres		CHA				ERAL SERV
~ A			23a. Part1. Enter the disease, or com	plications that caused the de	ath. Do not en	1230 ter the m	3_KA ode of dying	YAK j, such as c	DR, cardiac or	UPPEF respiratory a	R MA	RLBORO	MD 20772 Approximate
36	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	one cause on each line.	ATIC	( 6	NOIS	CA	ad C	-0		,	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a conse				011	P-0-0				
H	Lxammer	76	Sequentially list conditions,	b. Due to (or as a consi	equence of):								
	uted d ansit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events		,								
,09/	ate be executed hysicien and the burial-transit		resulting in death) Last	Due to (or as a conse	equence of):								
00	physic physic the b	dlcal		d									
Box 6	death certificate e eltending phys id for use as the	n/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of preg							2	3d. Date of del	ivery
Ď.	death	Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	1 □ Live birth 2 □ Fe 4 □ Pregnant at time of 9 □ Unknown		⊒Ectopic ☐ Other (	pregnancy (specify)					Month	Day Year
P. O.	hat the de id by the idetached		9 Unknown  Part II, Other significant conditions c		esulting in the u	inderking	T CALLSO CIVE	n in Part I		23e Did t	obacco u	se contribute to	the cause of death?
Division of Vital Records,	The law requires that the tte has been signed by the page 2 should be detache	d by	MARNTETON	J		· · · · · · · · · · · · · · · · · · ·	g sauso give	ATTITUDE OF				]No 3∏Pr	No.
S	s beer s beer	Completed	Pulmonotay n	WETATASIS						24a. Was		24b. Were au	topsy findings available completion of cause of
æ		mo								auto perfo	psy ormed? 2 No	death?	
/ita	rsician: The law s certificate has t lirector, page 2 s	Be	25. Was case referred to medical examiner?	U. alata N					of Death	(Check only			
0	Physic this cral dire	- T	1 Yes 2 No 27. Manner of Death		ER/Outpatie			4 🗆 1401		ne 5 Resi		Other (Spec	cify)
0	nding F ith. :: After e funera	tlon	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of Injury (Month, Day Year)	Injury	М	28c. Injury Work	:? ′es 2 □ N				33331133	
<u>N</u>	or Attending Physician: ifter death. Director: After this certifics in by the funeral director, i	Certification:	3 Suicide 6 Could not be determined	e 28e. Płace of Injury - At building, etc. (Spe	home, farm, st	reet, fact	ory, office		2	8f. Location ( City or To			iral Route Number,
	pitel o		200 Continu			the -	- d - s - t		1 - 10 -				
	To the Hospitel or Attend within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier 1 ☐ Certifying Ph (Check only 2 ☐ Medical Exam	nysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, deal nation and/or in	in occurre ivestigati	ed at the tim on, in my op	e, date and pinion, deat	piace, a h occurre	nd due to the id at the time,	date and	and manner as place, and due	stated. to the cause(s)
	To the within 2 To the complet	Me	29b. Signature and tile of)certifier			2	29c. License					signed (Monti	
)	SC		107				1)36	974			U	7/08/	ZWZ
	(2)		30. Name and address of person who	completed cause of death (It	em 23a) (Type,	Print)	PATUK	ant 6	PICWY	Cour			
1	Sta	ite	31. Date filed (Manth, Day, Year)	32. Red strar's 9	met.		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		1				-
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			For State Registrar	State of	Marylar		artmer rtificat			nd M		Reg. N	201	36	2337
	hysicia /Medic xamin	an al	Decedent's Name (First, Middle, La:     Myra Lee Hoffma     La: Facility Name (If not institution, give)	n	er)		4b. City.	Town. or	Location of	Death	2. Date of D Month July	8, 2	006	/ear Death	3. Time of Death 1:30 P M
	neral		Casey House  5. Social Security Number 6. S	өх 7.		last birthday)	Rocl	cvill			8. Date of 8 (Month, Dec.	м	ontoor	nery	ace (State or Foreign
Dir	ector		282-36-7716	□ M 2 🗓 F		ty, Town or Lo	Months	Days	Hours	Min.	Dec.	4, 1	940 Pe		ace (State or Foreign try) ylvania Od. Inside City Limits
ith the Man	or zee-r enow	Director	Maryland Montgome		Silv	er Spr	10f. Zip					-	itizen of Wh	at Count	1 □ Yes 2 No
er dea	natural, or items 238 or dical Examiner must be	by Fur	3000 Craiglawn Ro  11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	ad  12. Was Deceded Armed Force 1 X Yes 2 If Yes, Give Year or Date	es? ⊡No					in? (Spe Puerto I	cify Yes or N Rican, etc.)	USA lo-	14. Race -	America White, e	etc.
		Completed	15. Decedent's Ec (Specify only highest gra Elementary/Secondary (0·12)	ducation de completed) College (1-4	or 5+)	16a. Deced (Give life.	kind of wo DO NOT u	rk done d se retired	ation during most ( )	of workir	ng		Kind of Busi	ness/Ind	
ore, Maryland 2121 st and 2 should be filed within if health and Mental Hygiene.	If tem 27 le marked other then or other traumatic event, the Me	To Be Co	17. Father's Name (First, Middle, Last) Earl Hoffman						18. Mother Helen		(First, Middl right	1			
Te, Mar	other traum		19a. Informant's Name/Relationship ( Nelson D. Garber/ 20a. Method of Disposition		20b. F	3000	Crai	lawr	Road	Si	Route Num. 1ver S	Spri		209	904
Baltimore,	eny Injury or one		1 ☐ Burial 2 🏋 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 21. Signature of Funeral Service Licentification 22.	()		esapeak	e Cre	emato	ry 0		/06 Serv:	Be1	tsvill	le, M	Maryland
Exan	dical niner	Examiner	23a. Part1. Enter the disease, or com shock, or heart failurn. List only Immediate Cause (Final disease or condition resulting in dealh)  Sequentially list conditions, if any, leading to ammediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Cancer Due to (or  Due to (or	h line.	uence of):			g, such as c	ardiac oi	respiratory	arrest,			Approximate Interval Between Onsel and Death
Certif	led by the ellerlang physicien and detached for use as the burial-transit	Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑ No 9 □ Unknown	23c. If yes, outco	me of pregna 1 2 ∐ Feta t at time of d	ancy	Ectopic pr						23d. Date of Month		y Day Year
ecords, P.O. Bo law requires that the death	9 9	Ď	Part II. Other significant conditions o	ontributing to deat	h but not res	ulting in the u	nderlying c	ause give	n in Part I.	_					cause of death?
ت الله الله الله الله الله الله الله الل	page 2	Completed								_	perf 1 ☐ Yes	psy ormed? 20 N	prio	or to com th?	sy findings available pletion of cause of
of Vita Physician:	rus certific at director,	To Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☒ No	Hospital: 1 Inp	ationt 2 🗆	ER/Outpatien	t 3 DC	Cthe			Check only		a <del> </del>	ر. الم	ospice
Vision of Attending Phy	n. Alter mis ne funeral dii		27. Manner of Death  1    Natural 5 □ Pending 2 □ Accident investigation	28a. Date of I (Month,		28b. Time of Injury		8c. Injury Work	4 🗀 14013	2	Bd. Describe				ювртее
DIVISION TO the Hospitel or Attended Within 24 hours after death	completely filled in by the funer	Certification:	3 Suicide 6 Could not be determined	building,	etc. (Specif	y) 					City or To	wn, Sta	te)		Route Number,
To the Hospitel	pletely f.	edical	29a. Certifier (Check only one)  Check only 2 Medical Exert	ysician: To the be iner: On the basi and manner	s of examina	wiedge, dealt ition and/or inv	occurred restigation,	at the tim in my op	e, date and inion, death	occurre	nd due to the d at the time	cause(: date ar	s) and mann nd place, and	er as sta d due to t	ited. the cause(s)
Tot	Eoo	Σ	29b. Signature and tille of cert lier	<b>\</b> _	- 1	NK		. License					ate signed (/		
241)02			30. Name and address of person who Joseph Kaplan, M.				Print)			le,M	D 2085				
R	Stat legistra		31. Date filed (Month, Day, Year)	32. Re	strar's Signa										

			1 - For State Registrar	State of	Maryland		artment o				giene	00.0		
			Decedent's Name (First, Middle,	Last)				0. 2000		2. Date of De	ath L-	<del>U U 6</del>	3Time of	Death -
	Physici		DAVID J. Hu	MPHRE	4					July Month	Day 3	Year Zcc (e	1130	AM
	/Medic Examin		4a. Facility Name (If not institution,				4b. City, To	wn, or Location	n of Death	9-1		ounty of Death		
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D,	Funeral	15,150		5. Sex 7.	. Age (In yrs. la:	st birthday)	If Under 1 Y	ear If Und	er 24 Hrs.	8. Date of Bin (Month, Da	th	9. Birth	place (State or	r Foreign
h	Director		579-07-1534	10 <b>X</b> M 2□F	90	Yrs.	Months D	ays Hour	s Min.	Sept. 8	y, Year) 3. 191	.5 Ma	ryland	
	ס		Usual Residence of Decedent											
	how		10a. State 10b. County		10c. City,	Town or Lo	cation						10d. Inside Cit	
	e Ma	cto	Maryland Freder	ick	l l	Monro	via						1 🗌 Yes	XINO
	or 26	Director	10e. Street and Number				10f. Zip Co	ode			10g. Citize	n of What Cou	intry?	
	23a		12125 Gladhill	Brothers	Road			1770				S.A.		
	r deg	Funeral	11. Marital Status	12. Was Deced	es?	. 13.	Was Deceden If Yes, specify	t of Hispanic Cuban, Mexi	Origin? (Sp can, Puerto	ecify Yes or No Rican, etc.)	14.	Race - Amer Black, White		
36	s afte	by Fi	1 Never Married 2 Married 3 Widowed 4 Divorced	If Yes, Give	WWITT	[	1 ☐ Yes 2 🛱	No Spec	ify:		St	pecify: Wh	ite	
Ö	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28a-f ehow he Madical Excultar must be natified at	pe pe		Year or Date	es:		dent's Usual C	\acupation				of Business/Ir		
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Maryland 21215-0036	2 should be filed within 72 hours after death with the Marylan and Mental Hygiene is marked other then "naturel", or litems 23a or 28a-f show aumatic event, in a Maulice Exemination and the mailined at	To Be	Harry Baker	Humphrev					Oliv	e Agat	ha Ma	0.01.077		
2	should nd Men marke umatic	-	19a. Informant's Name/Relationshi	p (Type, Print)		19b. Maili	ng Address (S	treet and Nur		al Route Numbe			p Code) 21	.770
	and 2 ealth a n 27 is		Marian Humphrey	- Wife		1212	5 Glad	hill B	rothe	rs Road	Mo	nrovia		
altimore,	-I = =		20a. Method of Disposition	7772	20b. Pla	ce of Dispo	sition (Name	of		Date		tion - City or T		anu
9	Pages nent of I int: if its iry or o		1 ☐ Burial 2 ☑ Cremation 3 4 ☐ Donat on 5 ☐ Other (Spe		ate	-	itan Cr		i i i i i i i i i i i i i i i i i i i i	7/07/06	۸1۵	vandri	a, Virg	iinia
≣	permit. F Departm Importar any injur		21. Signature of Funeral Service Li		IIICEI	2	Name and A	Address of Fa	cility				-10	IIIIa
ñ	Depa Impo any i		Forest L	. Well	La.ms	Mc 26	leswor	th-Wil	liams	P.A., Damascu	Funer	al Home	e 20872	,
Ŋ.	· ·		23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that car	used the death.							Lyland	Approximate Interval Betw	•
	Physician		Immediate Cause (Final	-			BIEE	0					Onset and D	eath
	/Medical		disease or condition resulting in death)	-	TRACQUE		3319	0						
el.	Examiner										111			
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	cuted nd ransi	Examiner	Cause (Disease or injury that initiated events	c						110	TONE	Yu.		
760,	ate be executed hysician and the burial-transit		resulting in death) Last	Due to (or	r as a conseque	ince of):		-	1	VILED &	0			
376	ate b hysic the bi	licai		d					4	ON APPROVED &				
9	artifica ing ph e as th	Mec	IF FEMALE:			-			CERT CA	(10		1		
9	death certific attending pl	lan/	23b. Was decedent pregnant in the past 12 months?		th 2 ☐ Fetal d	leath 3[	Ectopic pregr		0- 9		230	d. Date of delive Month		'ear
O. Box	Physician: The law requires that the death certifica this certificate has been signed by the attending phare discounting of reading of a discounting of the detached for use as it.	Physician/Med	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	4□Pregnar 9□ Unknow	nt at time of dea vn	th 5	Other (speci	(ty)				WOTH	ouy .	ou.
<u> </u>	res that the de signed by the a I be detached f	Ph)	Part II. Other significant condition	s contributing to dea	th but not result	ting in the U	nderhing caus	o owan in Da	rd I	23a Did t	obacco use	contribute to	the cause of de	aath?
Records,	ires l signe d be d	þ	Tan II. Still significant seriamon	o contributing to doc	ar bat not rosan	ang ar mo u	ricerrying caus	so given iii i a				No 3□Pro	. 1	nknown
0	w require been si should b	Completed								-			, 1	
3ec	has l	mpi								24a. Was		24b. Were autoprior to condeath?	opsy findings a empletion of ca	ivailable luse of
	r: Th									1 ☐ Yes	No	1 Yes	20 No	
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Division of Vital	Attending or death.	tion	1 □Natural 5 □ Pending Accident investiga	(Month,	Day Year)	Injury	M	Injury at Work? 1 ☐ Yes 2	€No	Λ.		FALL		
S	deal deal ctor: y the	fica	3 Suicide 6 Could no	ot be 28e. Place o	Zکن ا		eet, factory, o			28f. Location (			al Route Numb	207.
Š	after Dire	Certification:	4 Homicide	building	, etc. (Specify)	lome				281. Location (: City or To	wn, State)	21256	IADITE	8
	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2		29a. Certifier 1 Certifying	Physicien: To the b	est of my know	ledge, deat	h occurred at t	the time, date	and place.	and due to the	cause(s) an	nd manner as	stated.	
	n 24 i	Medical	(Check only) 2 Medical E:	xeminer: On the bas and manne	sis of examination of stated.	on and/or in	vestigation, in	my opinion, o	death occur	red at the time,	date and pl	ace, and due	to the cause(s)	
	To the Hospital or A within 24 hours after To the Funeral Direcompletely filled in b.	×	29b. Signature and tille of certifier					icense numb	9r		29d. Date s	signed (Month,	Dey. Year)	
,	K		▶ 1h7-				15	1584			79	3/06		
1	7		30. Name and address of person w	ho completed cause	of death (Item 2	23a) (Type,					. 1 *			
_			SETH C. STUD.	0 7	22 50.7	THE GO	22 LNL	5).	39	mme	MO	, 212	3 1	
	Sta		31. Date filed (Month, Day, Year)	32.	gistrar's Signatu	ire								
	Registi		JUL 07	2006	en D	1								
DH	MH 17 Rev 1/2	001												

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Year **Physician** WARD 0951 DUIARD 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Regional Wicomic-MOSICOL RININSUA 5. Social Security Number If Under 1 Year 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1**33**M 2□F 76 Yrs. Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a State 10b. County 10d. Inside City Limits ст те глеткед other then "naturel", or items 23s or 28s-1 show treumetic event, the Medical Examinar must be notified at SALISBUR 1 XYes 2 □ No Directo ICDMIC MID 10e. Street and Number 10g. Citizen of What Country? death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status Peges 1 and 2 should be filed within 72 hours efter 1 Never Married 2 Married 1 Yes 2 No ģ Specify: BLACK 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) ) RIVER BARDON 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ELWOOD ၉ PORDNE LANCHE HAYWARD Baltimore, Maryl 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Department of Health a Important: if Item 27 is eny injury or other tret once. 20b. Place of Disposition (Name of cametery, crematory or other place) SALISBURY MID 2 1001 Date 2001 location - City or Town, State JOAN L. HAYWARD~WIFE 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify) EDEN HILL CEM. 06 21. Signature of Funeral Service Licensee FUNERAL HOME BENNIE ST. SALISBURY MD 23a. Part 1. Enter the disease, or complications that caused the death, shock, or heart failure. List only one cause on pach line. Approximate Interval Betwee Onset and D Do not enter the made of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Due to for as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): The law requires that the death certificate be executed physicien and s the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months? 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1032V 1 Tes 2 No 3 Probably 4 Winknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autonsy 1 Yes 2 No 1 ☐ Yes 2 No To the Hospital or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) 2 **9-1**0 Other: 4 \( \text{Nursing Home} \) 5 \( \text{Residence} \) 6 \( \text{Other} \( \text{(Specify)} \) 1 ☐ Yes 1 Inpatient ို 2 ER/Outpatient 3 DOA this 27. Manny of Death ieral Director: After th filled in by the funeral 28b. Time of Injury 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 Yes 2 No 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide within 24 hours etter To the Funeral Dire Descritiving Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year)

State Registrar 31. Date iled (Month, Day, Year)

560 Riverside Dr A102 Sausbury MD 21801

se of death (Item 23a) (Type, Print)

32. Registrar's Signature

			For	State	of Marylan					ind M	ental Hyg	giene	2006	23374
			State Registrer  1. Decedent's Name (First, Middle, I	actl		Cei	rtificate	of L	eatn		2. Date of Dea	Reg. No.	_000	3. Time of Death
	Physicia		MARION M. IRELAND								Month JULY	Day	2006	00:33 A M
•	/Medic Examin		4a. Facility Name (If not institution, g						Location of			4c. (	County of Death	
	Funeral			Sex	7. Age (In yrs.	last birthday)	If Under	1 Year	If Under 2	24 Hrs.	8. Date of Birtl	Year)		place (State or Foreign ntry)
	Director		216-78-4601	1 <b>X</b> M 2□ F	47	Yrs.	Months	Days	Hours	Min.	8. Date of Birtl (Month, Day 01/03/	1959	600	MD
	/land		Usuaf Residence of Decedent  10a. State 10b. County		10c. Cit	ty, Town or Lo	cation							10d. fnside City Limits
	e-feh	ctor	MD QUEEN	ANNE'S	C	HESTER	TOWN							1 ☐ Yes 2 🕅 No
	with the	Director	10e. Street and Number 113 BERRY COUR	Т			10f. Zip (	<sup>Code</sup> 2162	0			10g. Cítiz USA	en of What Cou	ntry?
	death	Funeral	11. Marital Status		cedent Ever in U	.S. 13.	Was Decede	ent of His	spanic Orig	gin? (Spe	cify Yes or No- Rican, etc.)	. 1	4. Race - Ameri Black, White	
36	within 72 hours after death with the Maryland ene. Then "netural", or items 23a or 28a-f show he Maulcal Examiner must be notified at	by Fu	1 ☐ Never Married 2 ☑ Married 3 ☐ Widowed 4 ☐ Divorced		2 No	-	1 🗆 Yes 2		Specify:	, , , ,			Specify: WH]	
Ž Ž	72 hours "natural", sulfal Exe	eted	15. Decedent's (Specify only highest of		)	16a. Dece	dent's Usual	l Occupa k done d	ition Juring most	of worki	ng	16b. Kir	d of Business/Ir	ndustry
21215-0036	within ane. then	Completed	Efementary/Secondary (0-12)		(1-4or 5+)	FORI	kind of work DO NOT use EMAN	e retired,				FO	RESTRY 1	PROCESSING
N	e filed Il Hygi other	Be Co	17. Father's Name (First, Middle, La			<u> </u>					(First, Middle,		Sumame)	
Maryland	2 should be and Mental Is marked o	TO B	MARION MILTON I		JR.						FLETCH			
	12 = 2		19a. Informant's Name/Refationship MARY IRELAND/WI			1	•				TERTOWN:		Town, State, Zi 21620	o Code)
Baltimore,	80		20a. Method of Disposition  1 XBuriaf 2 Cremation 3 4 Donation 5 Other (Spe		State	Place of Dispo cemetery, creat LY FAM	natory or ot	her place			0/2006		cation - City or T CH HILL	
Balti	permit. Pag Department Important: I eny Injury o		21. Signature of Funeral Service Lic	ensee	(i)	22 F 1	2. Name and ELLOW 30 SP	d Addres S H EER	s of Facility ELFEN ROAD,	BEIN CHI	AND NI	EWNAN	1 FUNERA 1D 21620	L HOME
			23a. Part1. Enter the disease, or co shock, or heart failure. List on	mplications that ly one cause on	caused the deat									Approximate Interval Between
	Physician /Medical		Immediate Cause (Final disease or condition resulting in death)	_ a^		lial:	In f	not	2000					Onset and Death
П	Examiner				o (or as a conseq	quence of):								
	P #	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	(or as a consec	quence of):								
•	te be executed ysician and e burial-transit	Examiner	that initiated events resulting in death) Last	c	(or as a consec	quence of):	<u> </u>							
3760,		icai		d										
89 X	leath certificat attending phy I for use as thi	/Med	IF FEMALE:	23c. If ves. of	utcome of pregna	ancy				****		2	3d. Date of deliv	ven/
Division of Vital Records, P.O. Box	Attending Physician: The law requires that the death certifica of death.  •ctor: After this certificate has been signed by the attending phy the funeral director, page 2 should be detached for use as it by the funeral director, page 2.	Physician/Med	23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		birth 2 Feta gnant at time of c nown		∃Ectopic pre ∃ Other (spe						Month	Day Year
ري. ص	res that the de signed by the a i be detached f	by Ph	Part If. Other significant condition	-1	death but not res	sulting in the u	nderlying ca	ause give	en in Part I.		23e. Did to	bacco u	se contribute to	the cause of death?
ord	w require been signature	ted	Hyperclists, tu	Ke-meel								es 2[		
l Rec	The law ate has b page 2 st	Completed		v						_	24a. Was autop perfor 1 Yes		24b. Were aut prior to co death? 1 \(\sum Yes\)	opsy findings available ompletion of cause of
Vita	tolan: sertific ector,	Be	25. Was case referred to medicaf examiner?	Hospital: 4				A Othe			(Check only o			
ō	Phys ar this aral dir	15	1 ☐ Yes 2 ☑ No 27. Manner of Death	28a. Date	of Injury	28b. Time o		8c. fnjury Work	4 140		me 5 Resid 28d. Describe h		Other (Special coccurred)	fy)
ion	auth. or: Afte	ation	1 Accident 5 Pending 2 Accident	ion	nth, Day Year)	Injury	М		r Yes 2□t	No				
<u>Š</u>	o at a	Certification;	3 □ Suicide 6 □ Could no 4 □ Homicide determin	28e. Plac	e of Injury - At h ding, etc. (Speci	nome, farm, st fy)	reet, factory	, office			28f. Location (S City or Tox			al Route Number,
ŧ	To the Hospital or Attending Physician: The law within 24 hours after death. To the Funeral Director: After this certificate has completely filled in by the funeral director, page 2	Medical (	29a. Certifier 1 Certifying (Check only one) 2 Medical Ex	Physicien: To the and ma	ne best of my kno basis of examina nner stated.	owledge, deat ation and/or in	h occurred a vestigation,	at the tim in my or	e, date and pinion, deal	d place, th occurr	and due to the e	cause(s) date and	and manner as place, and due	stated. to the cause(s)
	To the within To the comp	Me	29b. Signature and title of certifier	0	1. ~				number				signed (Month	-
) 	7		Jum K	1000	m)		2	)/7	103	<u></u>		7/	7/06	
13	ms		30. Name and address of person who Sus on K. Re	ss in D	use of death (Ite	m 23a) (Type, Was l	Print)	lus J	Ave.	. C	he. Int.	mes	1/06 Md- 2	1620
	Sta		31. Date filed (Month, Day, Year)		Registrar's Sign	ature		- 400						
44	Regist	rar	1111 1	0 2006	P Ballati		0.00	9						

16/06 102

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Arnette

			For	State of Ma					Mental Hy	giene	9	
			1- State RegistraAmend#16a.&]	6bPerFH PC	C 7-19	-Gel	tificate of	Death		Reg. No	2006	23376
	Physicia	an	Decedent's Name (First, Middle, Las	st)					2. Date of De	ath Da	y Year	3. Time of Death
	/Medic		Frances  4a. Facility Name (If not institution, give	Sharon Jo	nies		4b. City. Town. o	r Location of Death	July		2006 County of Death	9:13P <sup>M</sup>
	Examin	er	4136 Candy Apple				Suitla				rince Ge	orge
	Funeral		5. Social Security Number 6. Sec	ex 7. Age	(In yrs. last bir	thday)	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir (Month, Da	th		place (State or Foreign
	Director		227-60-1643	□M 2XF	61	Yrs.	Worters Days	Tiodis Willi	July 14			ginia
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Town	n or Lo	cation					10d. Inside City Limits
	Maryl	to	Maryland Prince G	George	Sui	itla	ınd					1 X Yes 2 □ No
	be filed within 72 hours after death with the Maryland all Hygiene. All Hygiene death with the Madical Examinar must be notified all event, the Madical Examinar must be notified all	Funeral Director	10e. Street and Number				10f. Zip Code			10g. Cit	tizen of What Cou	ntry?
	23a d	rai	4136 Candy Apple	Lane				746			ited Sta	
	er des	une	11. Marital Status	12. Was Decedent E Armed Forces?		13. \	Vas Decedent of H f Yes, specify Cubi	fispanic Origin? (Sp an, Mexican, Puerto	pecify Yes or No Rican, etc.)	)-	<ol> <li>Race - Ameri Black, White,</li> </ol>	
3	irs aft	by F	1 Never Married 2 Marned 3 XWidowed 4 Divorced	1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates:	0		☐ Yes 2፟【 No	Specify:			Specify: I	Black
5-0036	2 hou	ted	15. Decedent's Ed	fucation	16a.	. Deced	lent's Usual Occup	pation during most of work	king	16b. K	ind of Business/Ir	dustry
Š	ithin 7	Completed	(Specify only highest gra	College (1-4or 5+	+) E	1.1	TO MOT	inity Spe	•		Governm	ent
N	D		12 17. Father's Name (First, Middle, Last)	2		†- <u>P1</u>	umber	18. Mother's Nam			rivate	
and	buld be fill Mental Hi arked oth atic even	Ве	Samuel H. Morris					Gladys		, Maider	ourname)	
_	2 should I and Men ie marke eumatic	To	19a. Informant's Name/Relationship (7	Type, Print)	19b	. Mailin	g Address (Street	and Number or Ru		er, City	or Town, State, Zij	o Code)
	nd 2 lith a 27 is		Robert Jones, Jr.	/Son	2	15	E 80th St	#11G;	New Yor	k, N	Y 10021	
ore.			20a. Method of Disposition  1 Burial 2 Tremation 3	Removal from State	20b. Place of cemeter	f Dispo	sition (Name of natory or other plac	се)	Date	20c. L	ocation - City or T	own, State
Ĕ	Pages Iment of tant: If it lury or o		4 □ Donation 5 □ Other (Specify	v)	Metro			natory 7-8				Virginia
Baltimore,	permit. Page Department of Important: If eny injury or once.		21. Signature of Funeral Service Licen	"Wike	00	22	. Name and Addre		538 Marl	lboro	o Pike	
			23a. Part1. Enter the disease, or com-	plications that caused	the death. Do	not ent	er the mode of dyir				Md. 207	Approximate
	Physician		shock, or heart failure. List only Immediate Cause (Final				NoTo	. 0	563	C .		Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a. Due to (or as a	consequence	0):	MKIR	vy D	269	7-1		
	Examiner		Sequentially list conditions.	b								
	sit sd	lner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	consequence	of):						
	and and intran	Examiner	that initiated events resulting in death) Last	c Due to (or as a	consequence	of):						
8760,	certificate be executed ding physicien and use as the burial-transit	lical E	(	d								
89	tificate ig phy as the											
Box	eeth certifica ettending ph I for use as tf	Physician/Me	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of		3 🗆	Ectopic pregnancy	y			23d. Date of deliv	
0.	0 0	sici	in the past 12 months? 1 ☐ Yes 2 ☒ No 9 ☐ Unknown	4□Pregnant at t 9□ Unknown	time of death	5□	Other (specify)	<u> </u>			Month	Day Year
مـ	The law requires thet the take has been signed by the bage 2 should be detache		Part II. Other significant conditions of	ontributing to death bu	t not resulting in	in the ur	nderiving cause giv	ven in Part I.	23e. Did t	tobacco	use contribute to t	he cause of death?
ds,	uires the signed Id be de	d by	MITVZL	U 21 V ;	ST		2511		10	Yes 2	□No 3□Pro	bably 4 DUnknown
ဂ် ဝ	w require s been si	Completed	Cerebro	U2966	1120	A	ccid.	enT	24a. Was		24b. Were auto	opsy findings available
æ	The la te has	шо	<i>C</i> 0		- 10	10	2 rin 7	v.		psy ormed? 2 <b>%</b> No	death?	mpletion of cause of
<u>g</u>		BeC	25. Was case referred to medical examiner?	m e c	7 1	V (	EVINI	26. Place of Dea			,	
>	Physic this ce al dire	2	1 ☐ Yes 2 ☒ No		nt 2 ER/Ou		I JU DOA				6 ☐Other (Speci	<b>(</b> y)
Division of Vital Records,	ng I Iter	Certification:	27. Manner of Death 1 ⊠Natural 5 □ Pending	28a. Date of Injun (Month, Day	Year) 28b.	Time of Injury	Wo	ryat rk?  Yes 2 □ No	28d. Describe	how inju	ry occurred	
isic	or Attendi	fical	2 Accident investigation 3 Suicide 6 Could not be determined	e 28e. Place of Inju		arm, str		7.00 2			nd Number or Run	al Route Number,
2	P # # -	Sert	4 Homicide	building, etc	. (Specify)				City or To	wn, State	9)	
	hours unere	edical (	29a. Certifier 1 Certifying Ph	ysician: To the best o	f my knowledge	e, death	occurred at the til	me, date and place	, and due to the	cause(s	) and manner as s	stated.
	To the Hospital or Attenwithin 24 hours after deatl To the Funerel Director: completely filled in by the	Medi	one)	and manner star	ted.	10001111			1700 at 1170 time,			
	So T wit		29b. Signature and title of certifier	-01.			29c. Licens	PPG			ite signed (Month, $\circ$	-
7	1		30. Name and address of person who	completed cause of de	eath (Item 23a)	(Туре	Print)	1331		J /	- 0	- 0
	121		Jaime F. Botello,	M.D. 1328	Souther	rn A		Suite 309	; Washi	ngto	on, DC.	20032
	Sta	to	31. Date filed (Month, Day, Year)	32. Redietra	r's Signature							

DHMH 17 Rev 1/2001

Registrar

### 06-04704

Shawn A. Johnson

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

			- For State Registrar				Certific	ate of	Death			Re	eg No.	000	0007
	ysicia	n/	1 Decedent's Name (First, Midd	le,Last)							2	Date of Dea Month	th Day	Year	3 Time of Death
Medical E	xamir		Shawn				A.		John			July 4, 20	06		1313 hrs
			4a. Facility Name (if not institution 3055 Marshall Hall Ro	_	eet and nu	mber)		4	b. City, Town, o Indian Hea		of Death		4c Cou	inty of Deat les	h
Fun	eral	7	5. Social Security Number	6. Sex		7. Age (In	yrs last bir	thday)	If Under 1 Ye	ear If Unde		8. Date of Bir	th (MM/DD/Y		rthplace (State or
Dire			217-23-0913	1 <b>X</b> M	2F	33		Yrs	Months Da	ays Hours	Min.	9-01	-1972	Forei M&	ery/land
	any	$\perp$	Usual Residence of Decedent  10a State 10b. County			100	. City, Towr	or Location	n						10d. Inside City Limits
pur	#	5 P		rles	}				Head						1 X Yes 2 No
/lany-la	23a or 28a-f sho notified at once	ğ	laryland Cha 10e.Street and Number 9 Riverside						10f. Zip Code			1	0g Citizen o	of What Cou	untry?
the )	3a or	اة	9 Riverside	Run	Dri	ve			206	40			USA		
n with	ns 2. be n	Funeral	11. Marital Status		. Was Dec		r in US		Decedent of H					Race - Amer White, etc.	rican Indian, Black,
deat	or ite	틸	1 Never Married 2 X N	1	Yes	$^2$ X	No	l			, , , , , , , , , , , , , , , , , , , ,	iouvi, oto.)	1		,
s after	iner,	2			Dates:				Yes 2 X N		Lind of	di dana		cifyBla	
hours	'natural", Examiner	e le	<ol> <li>Decedent's Education (Spe Elementary/Secondary (0-12)</li> </ol>		College (1		(ed) 16a.		s Usual Occup st of working li				16b. Kind (	of Business	Industry
36 in 72	han ical	Completed	, , ,		College (	1~4 01 5+)	107	aroh	ousema	n			111	ΓZ	
-00 I with	other than the Medical	탉	12 17 Father's Name (First, Middle	Last)				aren	Ousellie		's Name (F	irst, Middle, I			
215-0036 be filed within 7 ntal Hygiene	it, th	Be	James Edwa				John	son		Rut	h	Ann	ì	Кi	ing
D 21215-00; should be filed with and Mental Hygiene	marked c event,		19a Informant's Name/Relations		Print )				Address (Str						
e, MD 21215-0036 1 and 2 should be filed within 72 hours after death with the Mary!and Health and Mental Hygiene	traumatic event,		Rebecca John	son	/ Wi	fe	9				Dr.	India			1D 20640
	f item		20a. Method of Disposition  1 X Burial 2 Cremation		Damayal fr	om Ctata		of Dispository or oth	tion (Name of o	emetery,		Date	20c, Local	tion - City o	r Town, State
MOI Pages ent of	- de l		4 Donation 5 Other S		Removanii	OIII State		•	Garder	ıs	7/14	/06	Wald	dorf.	Maryland
Baltimore, permit Pages 1 ar Department of Hee	Important: If item 27 injury or other traum:	1	21. Sign et f Funeral Service		-			22. N	ame and Addre	ss of Facility	2060	5 Aqu	asco	Road	3
<b>B</b> 20	I I I I	,01	depl &	20			191	Ad	ams Fu	ınera	1 Ho	me PA	, Aqua	asco	,MD,20608
Physi			23a Part I. Er ter the disease, or failure. List only one cause			aused the	death. Do r	ot enter th	e mode of dyin	g, such as c	ardiac or r	espiratory arr	est, shock, c	or heart	Approximate Interval Between Onset and
/Med Exam	_	- 1	Immediate Cause (Final disease	_	Itiple Gu										Death
		- 1	or condition resulting in death)	Due	to (or as a	conseque	ence of)								
		ē	Sequentially list conditions, if any, leading to immediate		to (or as a	conseque	ence of):								-
		Examiner	cause. Enter Underlying Cause (Disease or injury that initiated	С.	to (or as a	consocue	anca of\								
rted	d ansit		events resulting in death) Last	d.	10 (01 23 6	conseque	siice orj.								
e execu	ng physician and is the burial - transit	n/Medical	UNPENDED	_ A	MENDED										
<b>8760</b> , tificate be	physic he bu	Me	IF FEMALE:				f pregnancy						23d Da	te of deliver	
<b>687</b> Sertifi	nding se as t	ian	23b. Was decedent pregnant in t past 12 months?	ne 1	Live	oirth nant at time			al death 3	BEctopic	c pregnand	су	Mon	ith	Day Year
Box 68	e atter for u	Physicia	1 Yes 2 No 9 Ur	known				5 Oth	er (Specify)						
D. E	gned by the attending e detached for use a		Part II. Other significant condi	tions cor	ntributing t	o death bu	t not resulti	ng in the u	nderlying cause	e given in Pa	art I.	23e. Did to	obacco use o	contribute to	the cause of death?
P.(	-2'-2	d b										1 Ye	s 2 🗸 No	3 Pro	bably 4 Unknown
rds	been s	ete										24a Was			utopsy findings available completion of cause of
e law	e has	Completed							_				rmed?	death?	
<u>.</u> 8	tificat or, pa		25 Was case referred to medical	al I					26.Pla	ce of Death	(Check on		2 110	1 🗸 Y	2 110
/ita	uis cer direct	o Be	examiner? 1 ✓ Yes 2 No		oital: 1	Inpatient	2 ER/0	Outpatient	3 DOA	Other <sub>4</sub>	Nursing	Home 5	Residence	6 V Othe	er: Scene
of \	After this certificate has been s funeral director, page 2 should		27. Manner of Death		28a. Date	of Injury n, Day, Year)	28b	Time of Ir	jury 28c, Ir	njury at Work		8d. Describe		ccurred	
Division of Vital Records, P.O. and Attending Physician: The law requires that the safter death		Certification:		ding estigation	FOUNT Jul 4, 2			UND: 57 hrs	1	Yes 2 🗸	No S	ubject sho	τ		
VİSİ or At	Direct in by	ij	3 Suicide 6 Cou	ıld not be	28e. Plac	ce of Injury	- At home,	farm, stree	t, factory, office	e building, et	tc. 2	8f Location ( or Town, §		lumber or R	ural Route Number, City
	reral filled	E l	4 Momicide	ermined	(Specify,	Parki	ng Lot				31			d, Indian	Head, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or three frame in Physician: The law requires that the death certificate be executed swithin 34 hours after death	To the Funeral Director: After this certificate completely filled in by the funeral director, page	Medical	Concor only	aminer: O	the basis	of examin	_		ed at the time, on, in my opini						
To	To	S S	29b. Signature and title of certifi		d manner :	stated			29c. Lice	nse number			29d Date	signed (Mo	onth, Day, Year)
			1/	1					0.0	C.M.E.			July 5,	2006	
			30 Name and addr so of person	n who com	pleted cau	ise of deat	h (Item 23a)						I		
,151	D		Mary G. Ripple MD.				Examine		Penn Stre	et, Baltim	nore, MD	21201			
( )		ate	31. Date filed (Month, Day, Year,	2 200	32.	egistrar's	Signatura	Son	all s						
F	Regis	rar	JUL 1	ي ٢٥١	00	A STATE OF THE PARTY OF THE PAR	- ).	Jan Jan	210						

			1 - For Amend item#1,pe	State of MarInf,G857,7/	arylan 27/06		artmen <i>rtificat</i>			ınd Me	_	giene Reg. No.2 (	006	23378
	Physici		1. Decedent's Name (First, Middle, La	Jacob	S						2. Date of De Month	ath Day	Year 2006	3. Time of Death
	/Medic Examin	er	4a. Facility Name (If not institution, give Johns Hopkins 5. Social Security Number 6.5	Bayvier		ledical (ast birthday)	4b. City, Ba	lting	Location o	f Death	Date of Bir	th	ty of Death	place (State or Foreign
	Funeral Director		163-30-6093 Usual Residence of Decedent	<b>™</b> 2□F	67	Yrs.	Months	Days	Hours	AAim	(Month, Da Sept. 2	2, Year) 1938	Deca	utur, PA
	Ba-f ehow	Director	Maryland Cecil			y, Town or Lo	Sun							10d. Inside City Limits 1 ☐ Yes 2 No
	ath with the 23a or 21		10e. Street and Number  5 Lake Drive					1911				United	Stat	es
980	be filed within 72 hours after death with the Maryland tal Hygiene d other than "natural", or items 23a or 28a-f ehow event, I're Medical Examinar must be multified at	by Funeral	11. Marital Status  1 ☐ Never Married 2 ☑ Married  3 ☑ Widowed 4 ☐ Divorced	12. Was Decedent Armed Forces? 1 X Yes 2 ☐ If Yes, Give Year or Dates:	No		Was Deced If Yes, sped 1 ☐ Yes	cify Cubai	n, Mexican	gin? (Spec I, Puerto Ri	ify Yes or No ican, etc.)		ace - Ameri lack, White, sify: Wh:	
21215-0	l within 72 ho piene. r than "natu r e Medical	Completed	15. Decedent's E (Specify only highest gra- Elementary/Secondary (0-12)		5+)	life.	kind of wo DO NOT u	rk done d se retired,	luring most )	of working	esent		Business/Ir nment	
yland 2	should be filed ind Mental Hygi marked other umatic event, II	To Be C	17. Father's Name (First, Middle, Last Carl M. Jacobs						Sara	h E.	Winder			
Baltimore, Maryland 21215-0036	of Health ar item 27 is other trau		19a. Informant's Name/Relationship ( Helen M. Jacobs  20a. Method of Disposition 1□Burial 2☆Cremation 3 □			5 La	ke Dr	ive ne of other place	Risi		in, MD	21911 20c. Location	n - City or T	own, State
Baltim	permit. Pages Depertment of important: If it any injury or o		4 Donation 5 Other (Special 21. Signature & Pan Al Service)		Мау		2. Name ar	nd Addres	s of Facilit	y Crou		Newark neral H h East	ome	21901
	Physician /Medical Examiner	er	23a. Part 1. Enter the disease, or comshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, heading to minimediate	21.	a conseq	(La juence of):	er the mod		g, such as	cardiac or	respiratory a	rrest,		Approximate Interval Between Onset and Death
,8760,	The law requires that the death certificate be executed ate has been signed by the attending physicien and page 2 should be detached for use as the burral-transit	dicai Examiner	Sequentially list conditions, if any, leading to immodiate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.  Due to (or as	a conseq	juence of):								
P.O. Box 6	that the death certific ted by the attending p detached for use as i	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	23c. If yes, outcome 1 □Live birth 4 □ Pregnant a 9 □ Unknown	2 Feta	al death 3[	□Ectopic p □ Other (sp						Date of deliv Month	ery Day Year
	quires that in signed b uld be deta	Ď	Part II. Other significant conditions	contributing to death I	out not res	sulting in the u	nderlying o	cause give	en in Part I		1	obacco u <i>s</i> e co Yes 2 □ No	ontribute to t 3 ☐ Pro	the cause of death? bably 4 Unknown
of Vital Records,	The law requir ate hes been si page 2 should	Completed						-			24a. Was auto perte	psy ermed?	o. Were auto prior to co death? 1 \( \text{Yes}	opsy findings available ompletion of cause of
of Vita	Physician: The this certificate ral director, pag	To Be	25. Was case referred to medical examiner? 1 □ Yes 2 💢 No	Hospital: 1 🕱 Inpat		] ER/Outpatie			er: 4□Nu	ırsıng Hom		dence 6 □C		fy)
Division o	i or Attending Patter death. Director: After t	Certification:	27. Manner of Death  1 XNatural 5 Pending 2 Accident investigation 3 Suicide 6 Could not letermined	DO Diago of Is	ay Year)	28b. Time of Injury	М		yat k? Yes 2□	No	Bf. Location (	how injury occ		al Route Number,
biv	To the Hospital or Attending Physician: The I within 24 hours after death. To the Funeral Director: After this certificate he completely filled in by the funeral director, page		29a. Certifier 1 Certifying P	building, e hysician: To the bes miner: On the basis	t of my kn	fy) owledge, dea	th occurred	at the tin	ne, date ar	nd place, ar	City or To	cause(s) and	manner as	stated.
	To the Ho within 24 To the Fu	Medical	(Check only 2 Medical Example)  29b. Signature and title of certifier	and manner s		/ S		c. Licens			d at the time,	29d. Date sig		
	AVITO		30. Name and addr. ss of person who	completed cause of	death (Ite	m 23a) (Type	Print)	RES	SIU	JU L1	aryla	July	ð,	24
	St Regist	ate	31. Date filed (Month, Day, Year)	22. Regis	trar's Sign	ature	de la	urrl	016	1 1-1				

DHMH 17 Rev 1/2001

State

Registrar

31. Date filed (Month. Day, Year,

1 0 2006

32. Registrar's Signature

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 2006 L. King Month Year Mary **Physician** July 5:40AM M 5, /Medical 4a. Facility Name (If not institution, give street and number)
Southern Maryland Hospital 4b. City, Town, or Location of Death 4c. County of Death Examiner P.G. Clinton If Under 1 Year | If Under 24 Hrs. | Months | Days | Hours | Min. | 8. Date of Birth
Jan 26, 1949 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 578-66-0959 **Funeral** 1 ☐ M 2 🖫 F 57 Georgia Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Health and Mental Hygiene. Important: if Item 27 is marked other than "natural", or items 23a or 28a-1 show any injury or other traumatic event, the Medical Examinar must be notified at once. 10c. City, Town or Location
Temple Hills 10a. State 10b. County 10d. Inside City Limits P.G. MD 1 ☐Yes 2 ☐ No Director 10e. Street and Number 3458 Brinklry Rd. 10f. Zip Code 10g. Citizen of What Country? U.S.A. 20748 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 ☐ Yes 2 ☐ No If Yes, Give 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2√2 No Specify: Specify: Black þ 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry U.S. Custom Offic Elementary/Secondary (0-12) College (1-4or 5+) Secretary Fed. Gov. 12 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Herbert Benjamin Willie Mae Norman 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) James E. King-Husband 3458 Brinkley Rd. Temple Hills MD 20748 20b. Place of Disposition (Name of cometery, crematory or other place)
Fort Lincoln 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Brentwood, MD 7/12/06 of Funeral Service Licens Robinson Funeral Home 1313 6th St.N.W. 22. Name and Address of Facility 21. Signature 1 Inter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Non Small all Carun oma **Physician** resulting in death) /Medical Due to (or as a consequence of): Examiner Sacusatially list conditions if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner The law requires that the death certificate be executed attending physicien and for use as the burial-transit that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical as the IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 □ Yes 2 ☑ No Day Year 4☐Pregnant at time of death 5 Other (specify) detached the 9 Unknown 9 Unknown á signed Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 Probably 4 □Unknown 1 ☐ Yes 2 ☐ No peeu : 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an hes autopsy performed? certificate 1 Yes 2€ No 1 ☐ Yes 2 No Hospital or Attending Physician: To the Hospital or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certific completely filled in by the funeral director, 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 Inpatient ဥ 2 ER/Outpatient 3 DOA 28b. Time of 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury af Work? 28d. Describe how injury occurred Certification: 1. Natural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 ☐ Homicide Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier ical 29b. Signature and title of certif 29c. License number 29d. Date signed (Month, Day, Year) ah D0055120 5.2006 MD 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Kichard Palma Was hing bu Gin 1328 Southern avenue Sa Sute 310 DC 31. Date filed (Month, Day, Year)

JUL 0 7 2006 32. Registrar's Signature State Registrar

Judy Ann Kriox

06-05017 Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 1-For Stateamend #20b Per FH G861 Certificate of Beath 2. Date of Death 1. Decedent's Name (First, Middle,Last) 3-1 Time of Death Physician/ JUDY. ANN KNOX 1735 hrs **Medical Examiner** July 13, 2006 4a. Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Montgomery Holy Cross Hospital Silver Spring lf Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or 5. Social Security Number 6 Sex Age (In yrs. last birthday **Funeral** Foreign ASHINGTON Months Davs Hours Min Director 1957 NOV. 24 220-70-9314 48 1 M 2 X F DCUsual Residence of Decedent 10d Inside City Limits 10c City Town or Location any 10a State LANDOVER 1 X Yes 2 No PRINCE GEORGE'S MD is 23a or 28a-f show e notified at once. 28a-f show hours after death with the Maryland rector 10e. Street and Number 10f Zip Code 10g. Citizen of What Country? 20785 U.S.A. 3107 82nd AVENUE 14. Race - American Indian, Black, Funeral 11. Marital Status 12. Was Decedent Ever in U.S 13 Was Decedent of Hispanic Origin? (Specify Yes or Nomust be or items Armed Forces If Yes, specify Cuban, Mexican, Puerto Rican, etc.) White etc. 1 XNever Married 2 Married 2X No Yes BLACK 1 Yes 2 X No specify: Yes, Give Year Divorced Specify Widowed "natural". ģ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Completed Elementary/Secondary (0-12) College (1-4 or 5+) Pages 1 and 2 should be filed within 72 nent of Health and Mental Hygiene. event, the Medical marked other than Baltimore, MD 21215-0036 GOVERNMENT CORRECTION OFFICER 12th 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) RUBY MAE MCCLAINE EULIS KNOX SR Be 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) item 27 is 3107 82nd AVENUE LANDOVER, MARYLAND CHELA KNOX/DAUGHTER permit Pages .
Department of Heal'
Important: If iter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery 20c. Location - City or Town, State 7/2272006 crematory or other place) 1 K Burial 2 Cremation 3 Removal from State 6/22/2006 LANDOVER, MARYLAND HARMONY CEMETERY Donation 5 Other Specify J. B. JENKINS FUNERAL HOME 21 Signature of Funeral Service Licensee 22. Name and Address of Facility 7474 LANDOVER ROAD LANDOVER, MARYLAND 20785 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** failure. List only one cause on each line Between Onset and /Medical Death Complications of Hypertensive Atherosclerotic Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Cardiovascular Disease Sequentially list conditions. if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examiner (Disease or injury that initiated Due to (or as a consequence of): events resulting in death) Last the Hospital or Attending Physician: The law requires that the death certificate be executed and Sal X UNPENDED AMENDED 23a,27 per me g858 8-28-06 vt attending physician ian/Medi Records, P.O. Box 68760, IF FEMALE: 23b. Was decedent pregnant in the 23c. If yes, outcome of pregnancy 23d Date of delivery as the Live birth 3 Ectopic pregnancy Month Day Year Fetal death 2 past 12 months? Pregnant at time of death Other (Specify) Physici 5 1 Yes 2 No 9 V Unknown Unknown detached 1 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I Ş 1 Yes 2 No 3 Probably 4 V Unknown Completed 24b. Were autopsy findings available 24a Was an autopsy prior to completion of cause of death? performed? Yes 2 1 🗸 Yes No certificate 26 Place of Death (Check only one) 25. Was case referred to medica Division of Vital Be examiner? Hospital: 1 🗸 Inpatient 2 DOA After this 1 V Yes 2 No 28a. Date of Injury (Month, Day, Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of Injury 27. Manner of Death Certification: 1 X Natural 5 Pending 1 Yes 2 No Director: Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e Place of Injury - At home, farm, street, factory, office building, etc. Could not be Suicide or Town, State) (Specify) Homicide 29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical (Check only 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 and manner stated 29d Date signed (Month, Day, Year) 29b Signature and title of certifie 29c License number

OCME 2006

State

30 Name and address of person who completed cause of death (Item 23a)

Zabiullah Ali, M.D. Date filed (Month, Day Year,

Assistant Medical Examiner

O.C.M.E.

111 Penn Street, Baltimore, MD 21201

July 14, 2006

### Reginald Knowles, Sr. 06 2006 としして /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Prince George's Doctors Community Hospital Lanham If Under 1 Year If Under 24 Hrs. Months Days Hours Min. Month, Day, Year) 6/17/29 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1**⅓**M 2□F 77 Director Yrs 101-20-7836 Usual Residence of Decedent 10b. County 10a State 10c. City, Town or Location rthan "natural", or items 23a or 28a-f shov the Medical Examiner must be notilied at Director P.G. Bladensburg Md. 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5999 Emerson St. # 707 20722 U.S.A. Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? You so If Yes, Give Year or Dates: 1949 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 1 Never Married 2 Married 1 ☐ Yes XX No Specify: 1949 3 ☐ Widowed 4 ☐ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) ai Hygiene. Elementary/Secondary (0-12) 12th College (1-4or 5+) Chef Railroad other treumatic event, 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be 12 should be finand Mental F marked Octavious Knowles Bessie Dunk 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DeJon Knowles/Son Health tem 27 i 18402 Highway 87, Tar Heel, N.C. 28392 item 20b. Place of Disposition (Name of cemetery, crematory or other place) 7/15/05 20c. Location - City or Town, State Beltsville, Md. 20a. Method of Disposition Date permit. Pages Department of Important: if it any injury or o ō 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State Chesapeake Crematory, Inc. 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 29. Washington & Sons Co., Inc. 4925 Burroughs Ave., N.E., Washington, D.C. 20019

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

**Physician** /Medical Examiner

for use as the burial-transit

certificate

this

After

hin 24 hours after death.
the Funerel Director: A
moletely filled in by the fu

funeral director,

The law requires that the death certificate be executed

P.O. |

Division of Vital Records.

Hospital or Attending Physicien:

the s

Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last

in the past 12 months? 1 ☐ Yes 2 ☐ No

9 Unknown

Immediate Cause (Final

disease or condition resulting in death)

any

1 - State Registrar

**Physician** 

the Maryland

72 hours after

21215-0036

Baltimore, Maryland

1. Decedent's Name (First, Middle, Last)

23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death SEPSIS SYNDROME Due to (or as a consequence of): HEMICOLECTOMY SUBTOTAL Due to (or as a consequence of): BUEEDIN G DIVERTI W LAR Due to (or as a consequence of): Alwre RENAI 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 3 Ectopic pregnancy Day Month Year

Examiner Physician/Medical IF FEMALE: 23b. Was decedent pregnant Be Completed by Certification: To

9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.

5 Other (specify)

23e. Did tobacco use contribute to the cause of death?

RESPIRATORY FAILURE HYPER CAPNEIC

4 Pregnant at time of death

1) The

1 Yes 2 4 Orobably 4 Unknown

ANAEMIA AUDOSIS

24a. Was an autopsy performed? res 2 🖾 No 1 Yes

24b. Were autopsy findings available prior to completion of cause of death? 1 ☐ Yes 2 ☐ No

META BOUC 25. Was case referred to medical Hospital: 1 Impatient 1 ☐ Yes 2 ☑ No

26. Place of Death (Check only one)

Reg. No.

3. Time of Death

000 A M

Birthplace (State or Foreign Country)

10d. Inside City Limits

1 Yes 2 No

Brooklyn, N.Y.

Black, White, etc.

Black

2. Date of Death

Month

Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending

1 Natural investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be 3 Suscide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifiei (Check only one)

29b. Signature and title of certifier

29c. License number D0063658 29d. Date signed (Month, Day, Year)

workin

6

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

MD DR. HARINIDEVI. KRISHNAN, 4203 QUEENSBURY ROAD, HTATTSVILLE

State Registrar

Medical

31. Date filed (Month, Day, Year) 2006

32. Registrar's Signature

Amended

Physician

/Medical

Examiner

**Funeral** 

Director

ir than "natural", or Itama 23a or 28a-f show the Modical Examiner must be notified at

Direct

completed by

death with the Maryland

Baltimore, Maryland 21215-0036

Division of Vital Records, P.O. Box 68760,

	To Be	17. Father's Name (First, Middle, Last, EARL B. JOHNSON			lame (First, Middle, Maide NCE M. GILL	en Sumame)					
	-	19a. tnformant's Name/Relationship ( MARY MCGINNIS/S	**	19b. Mailing Address (Street and Number or 26795 MALLARD ROAD,							
once.		20a. Method of Disposition  1  Burial 2  Cremation 3  4  Donation 5  Other (Special	Removat from State	ace of Disposition (Name of imetery, crematory or other place) SAPEAKE CREMATORY 07		Location - City or Town, State					
once		21. Signature of Funeral Service Licer	Hetelen	22. Name and Address of Facility FELLOWS, HELFENB 130 SPEER ROAD,	EIN AND NEWN CHESTERTOWN,	IAM FUNERAL HOME MD 21620					
an		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition	pplications that caused the death one cause on each line.	Do not enter the mode of dying, such as card		Approximate Interval Between Onset and Death					
al er		resulting in death)	Due to (or as a consequence of the consequence of t	ence of):		10900					
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	Due to (or as a consequ								
		resulting in death) Last	Due to (or as a consequ								
	Physician/Medical	tF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1									
	۵	Part II. Office alignment content of a content of the content of t									
	Completed		24b. Were autopsy findings available prior to completion of cause of death?  No 1 Yes 2 No								
	Bec	25. Was case referred to medical examiner?	Death (Check only one)	heck only one)							
		Yes 2	Hospital: 1 thpatient 2 1	ER/Outpatient 3 DOA Other: 4 Nursing	Home 5 Residence	6 ☐Other (Specify)					
	Certification; To	27. Manner of Death 1 □ Natural 5 □ Pending 2 Accident investigatio	Month, Day Year)	28b. Time of Injury at Work?  ∠// A M 1 □ Yes 2 No	28d. Describe how inj	ury occurred					
	artific	3 Suicide 6 Could not be determined	On Diana of laises At ha	me, farm, street, factory, office	City or Town, Sta	•					
	Ö	29a. Certifier  (Check only one)  21 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  22 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as tated.									
		29a. Certifier 1 Certifying Pl (Check only one) 2 Medical Example	hysician: To the best of my know miner: On the basis of examinate and manner stated.		ccurred at the time, date a	nd place, and due to the cause(s)					
	Medical Co	29a. Certifier (Check only one)  29b. Signature and title of certifier	hysician: To the best of my know miner: On the basis of examination and manner stated.	ion and/or investigation, in my opinion, geath or	29d. D	Date signed (Month, Day, Year)					
		01(0)	in malling states.	23a) (Type, Print)	29d. D	ate signed (Month, Day, Year)					

			Please	State of Mar			Health and Mo	_	•	
			1 - For Stata Ragistrar	Otate of Mai		rtificate of			. No.	6 23384
	Physici	ian	1. Decedent's Name (First, Middle, La Joseph Roman					2. Date of Death Manth	Day Ye	3. Time of Death
	/Medic Examir		4a,Facility Name (If not institution, give	· M. / .	1 Center	4b. City, Town, o	or Location of Death	July	8 300 4c. County of E W/C	6 1113
	Funeral Director		5. Social Security Number 212–30–5503	_ /	(In yrs. last birthday, 73 Yrs.	Months Days	House Min	8. Date of Birth Month, Day Y Feb. 27,	<sup>9.</sup> 1933	Birthplace (State or Foreign Country) Maryland
boelore	hours after death with the Maryland turel', or Itams 23e or 28e-f show al Exercites must be notified a	'n	Usual Residence of Decedent  10a. State 10b. County		10c. City, Town or L		oridge			10d. Inside City Limits 1 ☐ Yes 2 ☑ No
8		Funeral Director	Maryland Dorches 10e. Street and Number 5616 Bar Neck R			10f. Zip Code 216:		10g	. Citizen of Wha	
	na 23	eral	11. Marital Status	12. Was Decedent Ev	ver in U.S. 13.			ofv Yes or No-		American Indian,
036 0	al', or Itan Examiner		1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces? 1 ☐ Yes 2 ☐ 10 If Yes, Give Year or Dates:		If Yes, specify Cub 1 ☐ Yes 2 ☐ No	Hispanic Origin? (Specian, Mexican, Puerto F	lican, etc.)		White, etc. White
21215-0036	ded o	Completed by	15. Decedent's E (Specify only highest grade) Elementary/Secondary (0-12)	du cation ade completed) College (1-4or 5+	(Give		during most of workingd)	g 16	b. Kind of Busine	ess/Industry
d 21	Hygiene ther the		7 17. Father's Name (First, Middle, Last,	1	Vice	Presiden	18. Mother's Name	(Eight Middle Ma	Sheet N	Metal
Maryland	marked other marked other matic avent, I	To Be	Adam Krepka				Mary	Labendz	ieski	
	lith ar 27 in r treu		19a. Informant's Name/Relationship ( Lucy H. Hearn/N		2698	6 Pratt 1	Rd., Salis	bury, MD	21801	
lore	, - = 0		20a. Method of Disposition 1 ☑ Burial 2 ☐ Cremation 3 ☐			matory or other pla	ce)		c. Location - City	
Baltimore,	Depertment of Important: If any injury or once.	1	4 □ Donation 5 □ Other (Special Service Licer			2 Name and Addre	ass of Facility			e, Maryland
Balt	Oepe Impo	0	Acher Hissas	- Home	oul	Curran-Bi 308 High	romwell Fu	neral Ho	me 21613	•
	hysician /Medical		23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)	a. Hepatea	the death. Do not en	ter the mode of dyii		respiratory arrest		Approximate Interval Between Onset and Death
760,	ysicien and unial-transit	dical Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c.	consequence of):					
O. Box 68	by the attending phy tached for use as the	Physician/Med	fF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No	23c. If yes, outcome of 1 □ Live birth 2 4 □ Pregnant at ti 9 □ Unknown	⊒Ectopic pregnanc ⊒ Other (specify) _	у		23d. Date of Month	defivery Day Year	
<b>Q</b> 3	been signed b should be deta	þ	Part II. Other significant conditions of	contributing to death but	not resulting in the u	underlying cause giv	ven in Part I.	23e. Did tobad	1	te to the cause of death?  Probably 4 Unknown
		Completed						24a. Was an autopsy performe	d? prior	e autopsy findings available to completion of cause of h? Yes 2 \sumbder No
of Vita	ector.	Be	25. Was case referred to medical examiner?	Hospitaf: V.		1.0#	26. Place of Death			
	r this eral di	7: To	1 ☐ Yes 2 🔭 No 27. Manner of Death	28a. Dite of Injury		III SLI DOA		e 5 Residence  8d. Describe how		Specify)
ion	ath. r: After e funer	atlor	1 Naturaf 5 Pending 2 Accident investigatio	(Month, Day)	Year) Injury		rk? ]Yes 2 □No			
Division	within 24 hours after death.  To the Funeral Director: A completely filled in by the ft	Certification:	3 Suicide 6 Could not b 4 Homicide determined		y - At home, farm, st (Specify)	reet, factory, office	2	8f. Location (Stree City or Town, S		r Rural Route Number,
] January	n 24 hour na Funer oletely fille	Medical (	29a. Certifier (Check only one) (Check only one) (Check only one)	nysician: To the best of minar: On the basis of e and manner state	examination and/or in	th occurred at the tinvestigation, in my o	me, date and place, as opinion, death occurre	nd due to the caus d at the time, date	se(s) and manne and place, and	r as stated. due to the cause(s)
بُّ	within 2 To the Complet	Σ	29b. Signature and title of certifier	1,1		29c. Licens	se number	29d	Date signed (M	fonth, Day, Year)
			30. Name and address of person who BENJAMIN H. MEYE	completed cause of dea	ath (Item 23a) (Type	Print\	Alisbury,	md 21.	801	
	Sta Registi		31. Date filed (Month, Day, Year)	1 2006 32. Registar	's Signature	Sports	//			

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month **Physician** July 7, THELMA LOIS PATRICIA LIU 2006 7:02 p /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Washington Adventist Hospital Takoma Park Montgomery If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Davs Hours Min. 1 ☐ M 2 💢 F Director 215-26-2975 Feb. 21, 1931 Maryland Usual Residence of Decedent the Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 27 is markad othar than "natural", or items 23a or 28a-f show traumatic event, "to Madical Examinat must be redified at 1 XYes 2 No Director Prince George's Maryland Hyattsville 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code Pages 1 and 2 should be filed within 72 hours after death with nent of Health and Mental Hygiene. U.S.A. 2803 Nicholson Street, Apt. 203 20782 Funerai 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☒ No Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14 Bace - American Indian Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Yes, Give Specify: White þ 3 ☐ Widowed 4 🕅 Divorced Year or Dates Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) 12 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Frank Young Etta Boswell 0 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20782 item 27 other tra - Daughter 2803 Nicholson Street, Apt. 203, Hyattsville, MD Ethel R. Liu 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 20c. Location - City or Town, State ō <u>=</u> ö 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 1 4 ☐ Donation 5 ☐ Other (Specify) Maryland National 7/13/2006 Laurel, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 allen Approximate Interval Between Onset and Death 23a. Part 1. Enter the disease, or emplications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition **Physician** ATHERO SCLEPUTIC HEART disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, any leading to it mediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 🖾 No Month Day Year 4☐Pregnant at time of death 5 ☐ Other (specify) 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 Yes 2 No 3 Probably 4 MUnknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a Was an has page 2 autopsy 2 No certificate 1 ☐ Yes To the Hospital or Attending Physician: Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 1 ☐ Yes 2 X No 1 ☐ Inpatient 2 X ER/Outpatient 3 ☐ DOA 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 27. Manner of Death 28d. Describe how injury occurred 1 Natural 5 Pending Injury after death. 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 24 hours a 29a. Certifier 🔣 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. cai 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of D48083 July 10, 2006 30. Name and address of person who complited cause of death (Item 23a) (Type, Print) Irving Westney, MD 7600 Carroll Avenue, Takoma Park, Maryland 20912 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUI 2006

**CRIGINAL** 

DHMH 17 Rev 1/2001

Baltimore. Maryland 21215-0036

Division of Vital Records, P.O. Box 68760.

			For 1 = State Registrar			d / Dep	artment of F	Health a	nd Mental Hy	giene Reg. No. 2	006	233	85
	Physici /Medio	***		Samuel	Little	Sr			2. Date of De Month July	7, 20	Year 06	3. Time of D	eath M
	Examin	er	4a. Facility Name (If not institution Fort Washin	gton Ho	spital	a at birthday	4b. City, Town, o	Vashir	ngton	Pri		George	
	Funeral Director		5. Social Security Number  579-46-2969  Usual Residence of Decedent	6.Sex 1 (★) M 2 □ F	7. Age (In yrs. I	8 Yrs.	Months Days	Hours	Min. 8. Date of Bi (Month, Date of Bi (Month, Date of Bi	1938		place (State or I intry) sh., DC	
	Maryland a-f ehow	ctor	10a. Slate 10b. Count	PG	10c. City	or L Oxon	ocalion Hill					10d. Inside City 1X Yes 2	
	ath with the	ral Director	10e. Street and Number 127 South Hu	ron Dri	/e		10f. Zip Code 2074	5		10g. Citizen Unite	d Sta	tes	
36	urs after dea ni, or iteme	by Funeral	11. Marital Status  1 □ Never Married 2 □ Ma  3 □ Widowed 4 □ Divorce	rried Armed F	2⊠No iive	S. 13.	Was Decedent of H If Yes, specify Cub 1 ☐ Yes 2 ☑ No	an, Mexican,	in? (Specify Yes or No Puerto Rican, etc.)	E	Race - Ameri Black, White Black		
Maryland 21215-0036	within 72 hours after death with the Maryland ene. than "natural", or Iteme 23e or 28e-f ehow he Mardical Examilian must be incitified at	Completed		nt's Education est grade completed College	(1-4or 5+)	(Give	dent's Usual Occup kind of work done DO NOT use retire	during most ( d)			f Business/Ir	ndustry	
and 21	d be filed wantal Hygier ted other ti c event, the	To Be Cor	6 17. Father's Name (First, Middle Leabender R			Wate	r Valve	18. Mother	rman s Name (First, Middle olyn V.	, Maiden Sun	_ `	nment	
, Mary	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or iteme 23s or 28s-f show any injury or other treumatic event, the Madical Examinat must be notified at once.	Ė	19a. Informant's Name/Relation Jacqueline G	ship (Type, Print)		127	ng Address (Street South D Hill,	and Number Huron	or Rural Route Numb			p Code)	
Baltimore,	Pages 1 at the tent of He tent: if iten		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation  4 ☐ Donation 5 ☐ Other (	Specify)	n State	lace of Disp emetery, cre	osition (Name of matory or other pla Mem. I	<sub>сө)</sub> Park 7	7/15/06		ver,	MD.	
Bal	Depermit Depermit Impor		21. Signature of Funeral Service  23. Part 1. Enter the disease, of	Edi	Caused the death	3	910 Silv	er H	Hodges &	Sulti	rds H and, N	F.H. 4D.2074 Approximate	46
	Fnysician /Medical		shock, or heart failure. Lis Immediate Cause (Final disease or condition resulting in death)	t only one cause on	each line.		AL IN					Interval Betwee	
	Examiner	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b	C VM G		E HEAR	IF FA	ILURE				
,092	icate be executed physicien and s the burial-transit	cal Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Due to	o (or as a consequ	uence of):							
P.O. Box 687	death certif e attending id for use a:	by Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 ☑No 9 □ Unknown	1 ☐ Live	utcome of pregna birth 2 ☐ Fetal gnant at time of de nown	death 3	□Ectopic pregnanc □ Other (specify) _	, NI	1-		Date of deliv Month	rery <b>V/H</b> Day Ye	)ar
	The law requires that the ste hes been signed by th bage 2 should be detache		Part II. Other significant condit	ions contributing to	death but not resi	ulting in the	underlying cause giv	ven in Part I.		tobacco use c Yes 2 ☐ No		he cause of dea	
Vital Records,	The lay	Completed							24a. Was auto perfo 1 🗆 Yes		b. Were auto prior to co death? 1 \( \text{Yes}	op sy findings av ompletion of cau 2 No	allable ise of
of Vita	Physician: Th this certificete ral director, pag	To Be	25. Was case referred to medic examiner?  1 ☐ Yes 2 No  27. Manner of Death	Hospital: 1	Inpatient 2	EP/Oulpalie	III JUDOA	ner: 4 🗆 Nurs	of Death (Check only sing Home 5 ☐ Res 28d. Describe	idence 6 🗆		fy)	
Division of	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Certification:	1 Natural 5 Pend 2 Accident inves 3 Suicide 6 Could	ing (Mo	nth, Day Year)	Injury ome, farm, s	Wo	rk? ]Yes 2□N	o 28f. Location			al Route Numbe	9 <i>r</i> ,
ā	Anspital or 24 hours afte Funerel Director filled in etely filled in		29a. Certifier 1 Certify (Check only 2 Madica	ing Physician: To the	ne best of my kno	wledge, dea	th occurred at the ti	me, dale and	place, and due to the	cause(s) and	manner as s	stated.	
	To the I within 2. To the I complet	Medical	29b. Signature and title of certific	and ma	nner stated.	· · · · · · · · · · · · · · · · · · ·	29c. Licens			29d. Dale sig	gned (Month,	Day, Year)	
K	15		30. Name and address of person Felton Ando	usum MI	7 94		Print)	Rd	# 350	First		144	MD
	Sta Regist	ate rar	31. Date filed (Month/Day, Yea	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	legistrar's Signa	ture 70	f						
DF	IMH 17 Rev 1/2	2001	JUL - ~ 200		- 7	ORIG	INAL						

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene? 1 - For State Registra Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Month Day Physician 35 06 05 490 MULTIP /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Kent Chatertown Nursing+Rohab 9. Birthplace (State or Foreign Date of Birth (Month, Day, 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday, **Funeral** Days SAUNI Months Hours Min 1 □ M 2 → POH-05-816 Director Usual Residence of Deceder 10h County 10c. City, Town or Location 10d. Inside City Limits 10a State in than "naturel", or items 23a or 28a-f show 1 PYes 2 □ No Completed by Funeral Director Kent 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 0 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) Was Decedent Ever in U.S. Armed Forces? 1 Yes 2 No If Yes, Give 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: 3 Widowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry ndary (0-12) College (1-4or 5+) LABORER 18 Mother's Name (First Middle Maiden Surname 17. Father's Name (First, Middle, Last) Be DAMUE 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City RION 10150 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Laction - City or Town, State Department of h Importent: If ite any injury or ot once. 1 Burial 2 Cremation 3 Removal from State • 4 ☐ Donation 5 ☐ Other (Specify) of Furieral S. M. Licer 22. Name and Address of 23a. Pan1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, show for heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition Physician CAR DIOPULMONAM /Medical resulting in death) Due to (or as a consequence of): neu teusen Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last as a consequence of Examiner Anteuschalie Heart Desease Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 🔲 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ò 1 Yes 2 No 3 Probably 4 □Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed 2 No 1 Yes Yes 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner' Hospital: 1 ☐ Inpatient 1 Yes 2 No 2 2 ☐ ER/Outpatient 3 DOA 4 Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) 27. Manner of Death Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred Certification: investigation 2 Accident

Examiner The law requires that the death certificate be executed use as the burial-Box 68760. physician attending p P.O. P the detached ģ Division of Vital Records, 99 page 2 should has certificate Hospital or Attending Physicien: director, this funeral After t hours after death. within 24 hours after death To the Funerel Director:

Pages 1 and 2 should be filed within 72 hours after death with the Maryland nent of Health and Mental Hygiene.

other than

is marked

item 27 i

treumatic event,

other

Baltimore, Maryland 21215-0036

6 Could not be determined

1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)

28f. Location (Street and Number or Rural Route Number, City or Town, State)

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Check only one) and manner stated 29b. Signature and title of certifier

3 🗌 Suicide

29a. Certifier

4 🗌 Homicide

29d. Date signed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

m, mil

State Registrar

Medical

31. Date filed (Month, Day, Year) 2006

Town C. ARRIBAL



State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3 Time of Death **Physician** 0917 AM 07 200C 10 jerome /Medical 4a. Facility Name (If not institution, give street and num 4b. City. Town, or Location of Death 4c. County of Death Examiner Baltimus ear If Under 24 Hs. Lauvesity May law Social Security Number 6. Sex 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min. 1₩ M 2□ F 73 177-26-7070 Director Jan 3, 1933 Pennsylvania Usual Residence of Decedent with the Manyland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10h County 27 is marked other than "neture!", or items 23s or 28s-f show treumatic event, the Modical Exemples must be invitibed at Penna Adams Hanover 1 ☐ Yes 3 ☐ No Director 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 46 Hill Road 17331 USA permit. Pages 1 and 2 should be filed within 72 hours after deeth 1 Department of Health and Mental Hygiene. Importent: If tem 27 is marked other then "neturer; or Items 23 entry liury or other treumatic event, the Medical Examiner must enter. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ⊕Yes 2 □ No 1952-If Yes, Give Year or Dates: 1954 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: 1954 white 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Plastering et land of work done during most of working Elementary/Secondary (0-12) College (1-4or 5+) Construction Plastering Concractor 8 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Charles J. Long Clara Irvin 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Miriam C. Long, wife 46 Hill Road, Hanover, PA 17331 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 07/13 Date 20c. Location - City or Town, State 1 ☑ Burial 2 ☐ Cremation 3 ☑ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Sacred Heart Cemetery Hanover, PA 2006 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Myers-Durboraw Funeral Home M01191 - Jan 91 Willis Street, Westminster, Md 21157 23a. Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) myocardial naction **Physician** /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner attending physicien and for use as the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 23d. Date of delivery 3 Ectopic pregnancy Day 4☐Pregnant at time of death 5 Other (specify) signed by the a 9☐ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 3 ☐ Probably 4 ☐ Unknown 1 Yes 2 No should t ange 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an s certificete has t canses autopsy performed: 200 1 Yes 1 Yes Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No ဥ 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury erei Director: After th filled in by the funeral 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred Certification; 1 Adjural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours a 29a. Certifier tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29c. License number P-19701 29d, Date signed (Month, Dav. Year) 29b. Signature and title of certifier A114176435E16775 WSL HD 10/06 20. TIVA 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) EYVAZZA DEH South Greene Street, Baltimor HD 21201 DANIEL 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 12 Registrar

Physicia /Medica		<ol> <li>Decedent's Name (First, Middle, Last</li> </ol>	1)					2. Date of De		V	3. Time of	Death
		Eva L. Logue						July	06	2006	3:00	p
Examine		4a. Facility Name (If not institution, give			,		ocation of Dea	ith		inty of Death		
- 4		2474 Wickes Driver 6. Security Number 6. Se		n yrs. last birthday)	If Under 1	nksbu	irg f Under 24 Hi	S. 9 Date of Bird		arroll	alaca (Stata a	r Fami
neral ector			M 2□XF	73 Yrs.			Hours Mi		1932	Cou	place (State of	D
Mor		10a. State 10b. County		oc. City, Town or Lo							IOd. Inside Ci	
Sa-f s	ctor	MD Carrol	<u> </u>	Finks	ourg			,			1 🗆 Yes	212
Le III	Dire	10e. Street and Number			10f. Zip 0		40		-	of What Cou	ntry?	
18 232	eral	2474 Wickes Driv	2. Was Decedent Eve	rin II S 13	Was Decede	2104		Specify Yes or No		SA Race - Ameri	an Indian	
xaminer	교	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces?  1  Yes 2 No If Yes, Give Year or Dates:	1	If Yes, specif		Mexican, Pue Specify:	Specify Yes or No into Rican, etc.)		Black, White,		
	Completed by	15. Decedent's Ed		16a. Dece	dent's Usual	Occupation	on ing most of w	arkina	16b. Kind o	f Business/In	dustry	
m" ne	nple	(Specify only highest grad Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use	retired)	ing most of w	orking		·		
of, the	Co -	To the last of the	2		Nur	sing	N 84-15-14-81	Comment Address		Medica	1	
is markad othar than aumatic svent, Ire M	To Be	17. Father's Name (First, Middle, Last)  Carl Robert Fish				1	Nancy	ame (First, Middle, Kershner				
or traum		19a. Informant's Name/Relationship (T Richard Logue/hush						inksburg		wn, State, Zip 21048	Code)	
mportant: If item 27 is marked other than "natural, or items 23s or 28s-1 show any injury or other traumatic svent, the Medical Examiner must be nutified at page.		20a. Method of Disposition  1   Burial 2 □ Cremation 3 □  4 □ Donation 5 □ Other (Specify,	Removal from State	20b. Place of Dispo cemetery, cree Evergree	matory or oth	ner place)		1 <b>0</b> 72006 ns		on - City or To sburg,		
Importa any inju once.		21. Signature of Funeral Service Licen	***	22				Home and Road Wes				57
physician and street transit sthe burial-transit sthe burial-transit street str	ical Examiner	if any, leading to immediate cause. Enter Under Ving Cause (Disease or injury	a. Due to (or as a co	onsequence of):	pum	ard	duc.	ass				
for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 ☐ Live birth 2 ☐ 4 ☐ Pregnant at tim 9 ☐ Unknown	Fetal death 3	⊒Ectopic pre ⊒ Other (spe				23d.	Date of delive		rear
ac,	by P	Part II. Other significant conditions co	entributing to death but n	ot resulting in the u	inderlying car	use given i	in Part I.	23e. Did to	obacco use o	contribute to t o 3 ☐ Prot	he cause of d pably 4 □L	
p eq	ed t	114224								b. Were auto	psy findings a	availat ause o
2 should be d	ompleted t	Hyportensin	0						rmed?	death?	2 □ No	
2 should be d	Completed	Hypertens in  Comp or tem  25. Was case referred to medical	discore			20	6. Place of D	autor perfo	osy rmed? 2 No	death?	2 No	
After this certificate has been signe funeral director, page 2 should be d	To Be Completed	examiner? 1   Yes 2   No 27. Manny of Death 1   Autural 5   Pending	Hospital: 1   Inpatient 28a. Date of Injury (Month, Day Ye	2 ☐ ER/Outpatier 28b. Time o lnjury		Other: c. Injury at Work?	4 🗌 Nursing	autop perfo 1 ☐ Yes	ne) dence 6	death? 1 ☐ Yes  Other (Specif		
After this certificate has been signe funeral director, page 2 should be d	To Be Completed	examiner? 1 Yes 2 No  27. Manny of Death	28a. Date of Injury (Month, Day Ye	28b. Time o Injury	M 28	Other:  c. Injury at Work?  1  Yes	4 🗌 Nursing	autor perfo	ned? 2 No ne) dence 6 now injury oc	death? 1 ☐ Yes  Other (Specificurred	y)	ber,
After this certificate has been signe funeral director, page 2 should be d	Certification; To Be Completed	examiner?  1 Yes 2 No  27. Manny of Death  1 Actural 5 Pending investigation  3 Suicide 6 Could not be determined  29a. Certifier Certifying Physics	28a. Date of Injury (Month, Day Ye	28b. Time o lnjury  At home, farm, str Specify)  ny knowledge, deat amination and/or in	M 28 M reet, factory,	other:  c. Injury at Work? 1 □ Yes office	4 ☐ Nursing	autopoperio autopoperio 1  Yes  eath (Check only of the desired of	ney new injury oc street and Na vn, State)	death? 1 Yes  Other (Special curred	iy) N Route Num. tated.	
After this certificate has been signe funeral director, page 2 should be d	To Be Completed	examiner?  1	28a. Date of Injury (Month, Day Ye  28e. Place of Injury building, etc. (s)  ysician: To the best of miner: On the basis of ex	28b. Time o lnjury  At home, farm, str Specify)  ny knowledge, deat amination and/or in	M reet, factory, h occurred a vvestigation, i	other:  c. Injury at Work? 1 □ Yes office	4 Nursing  t s 2 No  date and plation, death oc	autor period at the period 1 Tyes  eath (Check only of the period 28d. Describe I 28f. Location (\$'City or Toy on the period 28d. and due to the curred at the time,	new injury oc Street and Nove, State)	death? 1 Yes  Other (Special curred	(I Route Num. tated. o the cause(s	
After this certificate has been signe funeral director, page 2 should be d	Certification; To Be Completed	examiner?  1	28a. Date of Injury (Month, Day Ye 28e. Place of Injury building, etc. (sysician: To the best of miner: On the basis of ex	28b. Time o lnjury  At home, farm, str Specify)  ny knowledge, deat amination and/or in	M reet, factory, h occurred a vvestigation, i	Other:  c. Injury at Work?  1 □ Yes office  t the time, in my opini	4 Nursing  t s 2 No  date and plation, death oc	autor period at the period 1 Tyes  eath (Check only of the period 28d. Describe I 28f. Location (\$'City or Toy on the period 28d. and due to the curred at the time,	new injury oc Street and Nove, State)	death?  1 Yes  Other (Special curred)  Impor or Rure  I manner as see, and due to	(I Route Num. tated. o the cause(s	

DHMH 17 Rev 1/2001

ORIGINAL

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

2548 Old Field Point Road  Eltkton  Ceci  Funeral Director  5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/Months) Days Hours Min 03/23/1952  Usual Residence of Decedent  10a State 10b. County 10c. City, Town or Location	
4a. Facility Name (if not institution, give street and number) 2548 Old Field Point Road  5. Social Security Number 221-38-6012  Usual Residence of Decedent  10a. State  4b. City, Town, or Location of Death Eltkton  Funder 1 Year Months  Ab. City, Town, or Location of Death Funder 1 Year Months  10b. County  4c. Co Ceci  4c. Co	unty of Death  il  YYYY) 9. Birthplace (State or Foreign Country) Delaware
2548 Old Field Point Road  Eltkton  Ceci  Funeral Director  5. Social Security Number 221-38-6012  Usual Residence of Decedent  10a State  10b. County  Ceci  7. Age (In yrs. last birthday)	il  YYYY) 9. Birthplace (State or Foreign Country) Delaware  10d. Inside City Limits
Director  221-38-6012  Usual Residence of Decedent 10a State 10b. County  10c. City, Town or Location	Foreign Country) Delaware  10d. Inside City Limits
221-38-6012   1 M 2 XF 54	Country) Delaware
10a State 10b. County 10c. City, Town or Location	
Elkton	1 Yes 2 X No
The state of the s	
The state of the s	of What Country?
78 Old Ferry Road 21921 United 11 Marital Status 12 Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Drigin? (Specify Yes or No. 14.	1 States Race - American Indian, Black,
11 Marital Status 1 Never Married 2 X Married 1 Yes 2 X No 13. Was Decedent of Hispanic Drigin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. 15. Was Decedent of Hispanic Drigin? (Specify Yes or No- If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	White, etc.
3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify: Spe	cify: White
	of Business/Industry
To Decedent's Education (Specify only highest grade completed)    Specify only highest grade completed   168. Decedent's Stata Decapation (Give kind of work done during most of working life. DD NDT use retired)   Specify only highest grade completed   168. Decedent's Stata Decapation (Give kind of work done during most of working life. DD NDT use retired)   Specify only highest grade completed   168. Decedent's Stata Decapation (Give kind of work done during most of working life. DD NDT use retired)   Specify only highest grade completed   168. Decedent's Stata Decapation (Give kind of work done during most of working life. DD NDT use retired)   Specify only highest grade completed   168. Decedent's Stata Decapation (Give kind of work done during most of working life. DD NDT use retired)   Specify only highest grade completed   168. Decedent's Stata Decapation (Give kind of work done during most of working life. DD NDT use retired)   Specify only highest grade completed   168. Decedent's Stata Decapation (Give kind of work done during most of working life. DD NDT use retired)   Specify only highest grade completed   168. Decedent's Stata Decapation (Give kind of work done during most of working life. DD NDT use retired)   Specify only highest grade completed   168. Decedent's Stata Decapation (Give kind of work done during most of working life. DD NDT use retired)   Specify only highest grade completed   168. Decedent's Stata Decapation (Give kind of work done during most of working life. DD NDT use retired)   Specify only highest grade completed   168. Decedent's Stata Decapation (Give kind of work done during most of working life. DD NDT use retired)   Specify only highest grade completed   168. Decedent's Stata Decapation (Give kind of work done during most of working life. DD NDT use retired)   Specify only highest grade completed   168. Decedent's Stata Decapation (Give kind of work done during most of working life. DD NDT use retired)   Specify only highest grade completed   168. Decedent's Stata Decapati	sah
Secretary  Secretary  Secretary  Secretary  Secretary  Secretary  Secretary  James A. Trincia  Anna M. Testa	
James A. Trincia  Anna M. Testa  James A. Trinci	
Theodore Lambert, III/Husband 78 Old Ferry Road, Elkton, Maryla 200 Method of Disposition (Name of cemetery, Date 200 Method of Disposition (Name of cemetery, Date 200 Local National 2 Cremation 3 Removal from State National Property of other place) the odicated July 11,	and Z19Z1 ition - City or Town, State
Theodore Lambert, III/Husband 78 Old Ferry Road, Elkton, Maryla 20a Method of Disposition 1 XBurial 2 Cremation 3 Removal from State North East Methodist July 11, Cemetery Commenced of Disposition (Name of Cemetery North East Methodist 2006 North East Methodist 2006 North East Methodist 2006 North Cemetery 2006 North East Methodist 2006 North East Methodist 2006 North Cemetery 2006 North East Methodist 20	n East, Maryland
To see the see the see that the second of the specific forms and Address of Facility  200 Method of Disposition  1 XBurial 2 Cremation 3 Removal from State Cemetery  North East Methodist July 11, 2006  North East Methodist Cemetery  220 Name and Address of Facility  221 Name and Address of Facility  1 27 South Main Street North Facility	
12/ South Main Street, North	East, Maryland2190
Physician  /Medical  23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of failure. List only one cause on each line.	Approximate Interval Between Onset and Death
Fxaminer  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):	Deali
Sequentially list conditions,	
if any, leading to immediate  Due to (or as a consequence of):  cause. Enter Underlying Cause  C.	
if any, leading to immediate cause. Enter Underlying Cause (Disease of Lijury trat Littated events resulting in death) Last Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
OP Late Company of th	ate of delivery
past 12 months?   1   Live birth   2   Fetal death   3   Ectopic pregnancy   Mor	nth Day Year
So yes decerted pregnant in the past 12 months?  Nor and past 12 months	
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I 23e. Did tobacco use of the part	contribute to the cause of death?  3 Probably 4 Unknown
1 Yes 2 No	24b. Were autopsy findings available
24a. Was an autopsy performed? 1  Yes 2  No  25 Was case referred to medical examiner? 1  Yes 2  No  26 Place of Death (Check only one)  27 Was in autopsy performed? 1  Yes 2  No  28 Date of Injury 28c Injury at Work? 28d Describe how injury of Month Day Year)  28d Date of Injury 28c Injury at Work? 28d Describe how injury of Month Day Year)	prior to completion of cause of death?
The state of Death (Check only one)  25 Was case referred to medical examiner?	1 Yes 2 No
Assistance   Solution	6 🗸 Other: Scene
27. Manner of Death 28a. Date of Injury 28b. Time of Injury 28c Injury at Work? 28d. Describe how injury of 1809 hrs 28d. Describe how injury of 1809 hrs 28d. Describe how injury of 1809 hrs	
Use the state of t	
O sign to the part of the part	Road, Elkton, MD
29b. Signature and title of certifier  29d. Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and marginary and manner stated  29b. Signature and title of certifier  29c. License number  29d. Death occurred at the time, date and place, and due to the cause(s) and marginary and manner stated	and due to the cause(s)
29d. Date	signed (Month, Day, Year)
Patulioni - Pollin - O.C.M.E. July 7,	2006
30 Name and address of person who completed cause of death (Item 23a)  Patricia Aronica-Pollak MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
State 31. Date filed (Month, Day, Year) 1 200 32. Registrar's Signature	

06-05188 Nyheen Lucas

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

lyneen Lucas		I-For State    Certificate of Death		9 No 200	5 2239
Physicia	n/	1. Decedent's Name (First, Middle,Last)	2. Date of Death		3. Time of Death
Medical Examir		Nyheem Anthony Lucas  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Deatl	July 18, 20	4c. County of Death	1516 hrs
)		Good Samaritan Hospital  Baltimore		140. County of Death	
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hr.		n(MM/DD/YYYY) 9. Bir Foreig	
Director		122-68-2831 1X M 2 F Yrs. Months 2 Days Hours Mir	April 2		untry) MD
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Location			10d Inside City Limits
ž .		MD Baltimore			1 Yes 2 No
Maryland 28a-f show 1 at once.	ま	10e. Street and Number 10f. Zip Code	10	g. Citizen of What Cou	
ith the Maryland 23a or 28a-f sho notified at once.	<u></u>	1669 E. Coldspring Lane 21218		USA	
hours after death with the Maryland 'natural', or items 23a or 28a-f she Examiner must be aotified at once	Funeral Director	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? ( S 14. Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Puerto		14. Race - Amer White, etc.	can Indian, Black,
ter dea		1 Yes 2 No  3 Widowed 4 Divorced If Yes, Give Year  1 Yes 2 No specify:	,	Specify: Bla	ick
15-0036 filed within 72 hours after at Hygiene. ed other than "natural", o t, the Medical Examiner I.	함	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of		16b. Kind of Business/	
C1 2 -	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use ret	ired)		
15-003( filed within al Hygiene. ed other tha	팂	n/a   n/a 17. Father's Name (First, Middle, Last)   18. Mother's Name	e (First, Middle, M	n/a	l
21215-0036 uld be filed within 7 Mental Hygiene. marked other than	Be C	Tabari Allen Nashona		aiden Sumame)	
imore, MD 2121 Pages I and 2 should be finent of Health and Mental ant: If item 27 is marked or other traumatic event.		19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number or			
Baltimore, MD 2 permit. Pages I and 2 shoul Department of Health and M Important: If item 27 is n injury or other traumatic.	-	Nashona Lucas/mother 1669 E. Coldspring Lacob Method of Disposition 20b. Place of Disposition (Name of cemetery.)		20c. Location - City or	
Baltimore, permit. Pages I at Department of Het Important: If ite		1 Burial 2 X Cremation 3 Removal from State crematory or other place)		•	
Itim it. Pag irtment prtant:	+	4 Donation 5 Other Specify Crematory of Delmarva 7/2 21. Signature of Funeral Service Licensee 22 Name and Address of Facility		Delmar, M	D
Balt permit. Depart Impor injury		Lewis N. Watson Fr	uneral Ho	ome MD 21801	
Physician		23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory arres	st, shock, or heart	Approximate Interval Between Onset and
/Medical		Immediate Cause (Final disease a Sudden unexplained death in infancy			Death
,		or condition resulting in death)  Due to (or as a consequence of):  Sequentially list conditions,  b.			
	le	If any, leading to immediate Due to (or as a consequence of):			
=		(Disease or injury that initiated events resulting in death) Last Use to (or as a consequence of):			
760, icate be executed physician and the burial - transit		d.			
60, ate be ex ohysiciar ie burial	Medical	X UNPENDED	TT	Tool D-111-	
3876 rrifical ling ph		23b. Was decedent pregnant in the past 12 months?    TelwALE.   25c. If yes, butcome of pregnancy   25	ancy	23d. Date of delivery  Month	ay Year
Box 687 death certifines: the attending of for use as t	sician	1 Yes 2 No 9 Unknown 9 Unknown			ì
O. Bo it the de by the ached f		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	23e. Did tob	acco use contribute to	the cause of death?
ires that the signed by the detache	å Š		1 Yes	2 No 3 Prob	ably 4 Unknown
ords w requi	iş Ş		24a. Was ar autops		topsy findings available ompletion of cause of
Division of Vital Records, tal or Attending Physician: The law requir is after death. Ther this certificate has been seled in by the funeral director; page 2 should be in by the funeral director; page 2 should be in the funeral director.	Completed		perform 1 <b>V</b> Yes 2		s 2 No
tal F	8	25. Was case referred to medical examiner? Hospital: 1 Inspired: 2 FB/Outpetiest 2 DOA Other Number 1	only one)		
f Vir	의	examiner? 1 Ves 2 No  1 No  1 No  28a. Date of Injury  28b. Time of Injury  28c. Injury at Work?		esidence 6 Other	:
on of nding Pt. th.	ë	1 Natural 5 Pooding (Month, Day, Year)		w injury occurred	
ivisior or Attendather death Director:	lica	Accident  Accident  Suicide  Suicide  Accident  Could not be  Suicide  Accident  Could not be  Suicide  Accident  Suicide  Suicide  Accident  Suicide  Accident  Suicide  Accident  Suicide  Accident  Suicide  Accident	unknown 28f. Location (St	reet and Number or Ru	ral Route Number, City
Division pital or Attenc ours after death eral Director: filled in by the	Certification:	4 Homicide determined (Specify) found in residence	Baltimore	te)1214 Glenhar , MD	ven Koad
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transi	- 1	29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and (Check only one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred a			
To tl To tl comp	Medical	2 Medical Examiner: On the basis of examination ana/or investigation, in my opinion, death occurred and manner stated.  29b. Signature, and title of certifier  29c. License number		29d. Date signed (Mor	
	_	MI DE MANAGER ALLO		July 19, 2006	
	+	30. Name and address of person who completed cause of death (Item 23a)			
		Melissa Brassell, MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD	21201		
Sta Regist	ite rar	31. Date filed (Month, Day, Year)  32. Registrar's Signature			
DHMH 17 Rev 1/20		ORIGINAL			

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 3. Time of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month 22:45 2006 Physician July Deloris Solomon Moseley /Medical 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (If not institution, give street and number) **Examiner** Prince George's If Under 1 Year If Under 24 Hrs.
Hours Min. Ft. Washington Ft. Washington Hospital Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Days **Funeral** 1 □ M 2 🖸 F 17, 1931 North Carolina Dec. 244-48-0884 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location with the Maryland 10b. County 77 is marked other than "natural", or Itams 23a or 28a-f show traumatic event, the Medical Examiner must be notified at 1 XYes 2 No Greenbelt Prince George's Maryland Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number United States 20770 9011 Breezewood Terrace, #103 death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after c Department of Health and Mental Hygiene. Important: If Item 27 is marked other than "natural, or Item any injury or other traumetic event, the Madical Enabline African 1 □XYes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 TNo Specify Specify: Baltimore, Maryland 21215-0036 3 ☐ Widowed 4 ☐ Divorced American þ 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Completed 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Office Support Specialist Government 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Lucille Brice Oliver Solomon 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) Greenbelt, MD 20770 9011 Breezewood Terr., #103 Linda Solomon/Daughter 20c. Location - City or Town, State 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State 7/11/2006 Brentwood, MD Lincoln Cemetery 4 Donation 5 Other (Specify) 22. Name and Address of Facility Stewart Funeral Home 21. Signature of Funeral Service Licensee Wash., DC 20019 4001 Benning Rd., NE 23a. Part1. Enter the disease, or complications that caused the death). Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one caution each line.

Immediate Cause (Final disease or condition resulting in death).

Due to (or as a consequence of): Approximate Interval Between Onset and Death rat Physician /Medical **Examiner** Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit that initiated events Due to (or as a consequence of): resulting in death) Last Box 68760 attending physicien for use as the buria Physician/Medical IF FEMALE: 23d Date of delivery 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23b. Was decedent pregnant 3 Ectopic pregnancy Year Month Day in the past 12 months? 4☐Pregnant at time of death 5 Other (specify) ed by the a P.O. 9☐ Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. been signed 2 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Records, Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? has page 2 1 ☐ Yes 2 ☐ No 1 Yes 2 No Division of Vital 26. Place of Death (Check only one) 25. Was case referred to medical examiner? director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 ER/Outpatient 3 DOA 1 Appatient 1 Yes 2 No Certification: To this 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 28a. Date of Injury (Month, Day Year) filled in by the funeral 27. Manner of Death After Attending 5 Pending 1 ☐ Yes 2 ☐ No A Hospitel or Attending 24 hours after death. Punerel Director: Aft investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide within 24 hours a To the Funerel C Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

I Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical and manner stated. ě 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 0 6.3 46046 30. Name and address of person who completed cause of death (Item 231) Clark, Print) 17111 Livingston Rd., Ft. Wash., MD 20744-5164 M.D. Dr. Mirza Alikhani, 31. Date filed (Month, Day, Year) 32. Registrar's Sign State JUL

DHMH 17 Rev 1/2001

Registrar

	/Medic	cai				LICIC	CITEWS				Jung	
	Examir	ier	4a. Facility Name (If not institution  Doctors Commun		-		4b. City, I Lanh		Location	of Death	,	1
	34.467° c	Ÿ	5. Social Security Number	last birthday)								
	Funeral			6. Sex 1⊠ M 2□ F	48	Yrs.	Months	Days	Hours	Min.	8. Date of E (Month, I	Sirth Day, Yea
4	Director		578-74-8288 Usual Residence of Decedent			113.					Nov. 1	2, 1
	pug *		10a. State 10b. County		10c. Cit	ty, Town or Lo	cation					
1	ges 1 and 2 should be filed within 72 hours after death with the Maryland it of Health and Mental Hygiene. If item 27 is marked other than "natural", or Itema 23a or 28a-1 show or other traumatic event, the Macalcal Examiner must be notilised at	Funeral Director	D.C. Washington,									
)	7 28 P	ē	10e. Street and Number				10f. Zip (	Code				10g. 0
	7 wit	ag .	1306 13th ST.	NW;			2	2000	1			
	dead	ner	11. Marital Status	12. Was Deci	edent Ever in U		Was Decede	ent of Hi	spanic Ori	gin? (Sp	ecify Yes or I	10-
9	after Pr Ite	T.	1 Never Married 2 ☐ Marr		2 □ No 19	<del>1</del> 80 –				і, Риепо	Rican, etc.)	
ස	all,	by	3 Widowed 4 Divorced	If Yes, Gir Year or D	ates: 1	983	1 ☐ Yes 2	IXI NO	Specify:			
Baltimore, Maryland 21215-0036	72 ho	Completed	15. Deceden	it's Education st grade completed)		16a. Deced	lent's Usual	Occupa	ition	e of work		16b.
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2	od wi	20	12				Transp	port	ation	ı Wo	rker	
b	al Hy	Be (	17. Father's Name (First, Middle,								e (First, Midd	le, Maide
<u>a</u>	ouid be i Mental H arked of	2	David Matt	hews					Ru	ith .	Jones	
a <sub>1</sub>	nd 2 should be filed within and Mental Hygiene. 27 Is marked other than r traumatic event, the Mental Research in		19a. Informant's Name/Relations	hip (Type, Print)							al Route Num	
$\geq$	fealth a tom 2 fealth a tom 27 la		Vernon Matthews	/Brother		5901	Cherry	ywoo	d Lar	ie;	Greenbe	e1t,
อ์	es 1 a of Hei fitem r othe		20a. Method of Disposition			Place of Dispo	sition (Name	g of	->		Date	20c.
ဥ	age ant o at: # y or		1 XBurial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (S			mony M				ı1v	10,2006	I
量	permit. Pag Depertment Important: sny injury once.		21. Signature of Funeral Service			-				Por	e Fun	eral
Ba	permit. Depertr Imports sny in		Doub OL	Enga No	100-	-	5538 Mar1					
	100	-	23a. Part1. Enter the disease, or	complications that o	aused the doct	h. Do not onte	or the made	of chance	- auch aa		restvi	
			snock, or near tailure. List	only one cause on e	ach line.	n. Do not ent		OI CIVILIE	, sucii as	Carulac	or respiratory	arrest,
	Pnysician		Immediate Cause (Final disease or condition resulting in death)	- a KESP	18910	Ry t	ALLI	rri	=			
7	/Medical Examiner		resulting in death)	Due to	or as a conseq	uence of):			$\wedge$			
	Examiner.		Sequentially list conditions.		TRUCTI		LEE	P	HPI	YOE	<del>(</del> )	
	D #	ine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to	or as a conseq	uence of):		- 1				
	that the death certificate be executed ed by the attending physician and detached for use as the burial-transit	Examiner	that initiated events resulting in death) Last	a Chim		IMPE	111	JVL	02161	W	OBERI	TY
Ö,	e exe		resulting in death) Last	Due to	or as a conseq		,		1	-		
Box 68760,	ate b nysic he bi	Physician/Medical		d. 1016	BEIE	5 1116	UITO	LS_	176	E,	U	
39	ng ph	Med	IF FEMALE:									
õ	th ce tendi r use	an/l	23b. Was decedent pregnant		come of pregna		Ectopic pre	nnancy				
Ξ.	dea le atl	sici	in the past 12 months?  1 Yes 2 No		ant at time of d		Other (spec					
P.O.	t the by the tachie	hys	9 Unknown									
	<b>≠</b> 60 0	by F	Part II. Other significant condition	ons contributing to de	eath but not res	ulting in the ur	nderlying car	use give	n in Part I.		23e. Did	tobacco
Ö	w requires the been signed should be d	pe	HYPERTENL	Sconl .							1	Yes 2
္ပ	The law requires ite has been sign bage 2 should be	Completed	PERINEAL	CEUU	TIS						24a. Wa	s an
Be	he la e ha:	E	10111600	CE CER	Cres						auto	opsy formed?
a	n: T ficate or, pe	e C	25. Was case referred to medical								1 Yes	2 <b>X</b> N
₹	Attending Physician: The law in death. ector: After this certificate has by the funeral director, page 2	0	examiner?	Hoonital:				Othe	r,		(Check only	
o	Phys this ral dii	2	1 Yes 2 No 27. Manner of Death	28a. Date (		ER/Outpatient		1	4 🔲 Nui		me 5 Res	
L C	Jing After fune	io	1 Natural 5 ☐ Pendin	g (Mont	h, Day Year)	28b. Time of Injury		c. Injury Work			28d. Describe	now infi
S	death death ctor: /	cat	2 Accident investig	not be			М		es 2 🗆 N			10
Division of Vital Records,	or Al	Certification:	4 Homicide determ	ined 286. Place	of Injury - At hong, etc. (Specify	ome, rarm, stre V)	eet, factory,	office			28f. Location City or To	(Street a
	urs a	ပိ	00-0-0									
	Hoss Hone Fune	edical	Check only 2 Medical	g Physicien: To the Examiner: On the ba	asis of examina	wledge, death tion and/or inv	occurred at estigation, in	the time	e, date and inion, deat	place, a	and due to the	a cause(:
	To the Hospital or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	Med	57167	and manr	ner stated.							
	Mit Wit	-	29b. Signature and title of certifier	570			29c.	LICENSE	number			29d. Da
1	*			D)	un		DE	104	103	29		07
1.	. 10	- 1										

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

PARATIOE A

1- State #1 per phy,gc,7/12/06 1. Decedent's Name (First, Middle, Last) P∦îysician 2. Date of Death Month Day Nathaniel L. Mathews Matthews 2006 c. County of Death Prince George Birthplace (State or Foreign Country) 957 Wash, DC. 10d. fnside City Limits 1 Yes 2 □ No Citizen of What Country? United STates 14. Race - American Indian, Black, White, etc. Specify: Black Kind of Business/Industry Government on Sumame) or Town, State, Zip Code) 20770 MD. Location - City or Town, State Landover , Md. Homes o Pike Md. 20747 Approximate Interval Between Onset and Death 23d. Date of defivery Month Day Year use contribute to the cause of death? 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 6 Other (Specify) ury occurred and Number or Rural Route Number, s) and manner as stated. nd place, and due to the cause(s) ate signed (Month, Day, Year)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

Certificate of Death

DHMH 17 Rev 1/2001

State Registrar

HAMOVER

1325A

PLWY, CREENBERT. MO. 20220

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Month Year **Physician** 6:11 P M Lawrence July 6, 2006 A. Mangum /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 6110 Cipriano Road Lanham Prince George's If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In vrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 □ MM 2 □ F Yrs. 578-22-4108 81 Nov 8, Director Maryland Usual Residence of Decedent 10c. City. Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f show is than "natural, or Items 23a or 28a-f show the Neolest Examinate was be notified at 1 XYes 2 ☐ No Directo Maryland Prince George's Lanham 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6110 Cipriano Road 20706 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. 72 hours after 1 Z Yes 2 ☐ No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Tes 2€ No Specify: Specify 3 ☐ Widowed 4 ☐ Divorced White 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) Elementary/Secondary (0-12) 8th marked other than College (1-4or 5+) Businessman Private Ith and Mental Hv 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Mangum Ida Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s of Health an item 27 ls Gladys Mangum (Wife) 6110 Cipriano Road, Lanham, MD 20706 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Pages nent of h 1 ☐ Burial 2 Incremation 3 ☐ Removal from State ö permit. Page Department of Important: If any Injury or once. 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Crematory 7/8/2006 Beltsville, MD 21. Signatur of F neral Solvice Licens 22. Name and Address of Facility Rendon/Hale Funeral Home 9013 Annapolis Road, Lanham, MD 20706 . Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final tastr Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to initine date cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner Qualto for as a consequence of certificate be executed burial-transi Due to (or as a consequence of) Box 68760, physician Physician/Medical use as the IF FEMALE If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Day Month Year 5 Other (specify) 4☐Pregnant at time of death P.0. 9 Unknown ģ signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has page 2 1 Yes 2€ No 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 TResidence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 Tes 2 XNo ၉ this 28b. Time of Injury 27. Manner of Death Date of Injury (Month, Day Year) 28d. Describe how injury occurred Certification: 1 XNatural 5 Pending investigation death. 1 ☐ Yes 2 ☐ No 2 Accident after death 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide Hospital or Within 24 hours a To the Funeral C Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a, Certifier 2 Medical Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) (Chec manner stated. the 29b. Signa nd title of certifier 29c. License number 29d. Date signed (Month, Day, Year) IL D19191 July 7, 2006 address of person who com leted cause of death (Ite 23a) (Type, Print) Jack D. Francis, M.D. 7500 Hanover Parkway, Greenbelt, MD 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar 2006 DHMH 17 Rev 1/2001

**ORIGINAL** 

			4 000	•	•			Mental Hyg	ene	0000
			Registra AVEND#14perFH7/11/06, EMW, 1  1. Decedent's Name (First, Middle, Last)	<u>MbCo</u>	Cei	rtificate of	Death	2. Date of Deat	g. No.	3. Time of Death
	Physici		RONALD J.	MILLS				Month JULY	Day Year 5, 2006	10:00 P <sup>M</sup>
ń.	/Medic Examin		4a. Facility Name (If not institution, give street and number			4b. City, Town, o	or Location of Deat		4c. County of Death	
			SHADY GROVE ADVENTIST HO	OSPITAL		ROCKY	VILLE		MONTGOME	ERY
	Funeral Director		5. Social Security Number 6. Sex 7. A	ge (In yrs. last b	oirthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	8. Date of Birth (Month, Day, NOV • 20	9. Birth Cot , 1945 MI	place (State or Foreign intry) CHIGAN
	pue *		Usual Residence of Decedent  10a, State 10b, County	10c. City, To	wn or Lo	eation				10d. Inside City Limits
	daryla f ebo	ō	MD. MONTGOMERY	1001 01197, 10	01 20	GAITHERS	RURC			112 Yes 2 □ No
	28e-	Director	10e. Street and Number			10f. Zip Code	DORG	10	ng. Citizen of What Cou	intry?
	h with		17 WATER ST. #6			208	77		U.S.A.	•
920	should be filed within 72 hours after death with the Maryland nd Mental Hygiene. marked other than "naturel", or iteme 23e or 28e-1 ehow imatic event, it a Medical Examinat runal be notified at	by Funeral	11. Marital Status  1	?  No	'	Was Decedent of H f Yes, specify Cub 1 ☐ Yes 2 No	dispanic Origin? (S an, Mexican, Puer Specify:	Specify Yes or No- to Rican, etc.)	14. Race - Amer Black, White American Specify:	, etc.
ည်	72 hornatur	ted	15. Decedent's Education (Specify only highest grade completed)	16	a. Dece	dent's Usual Occup	pation	rking	6b. Kind of Business/li	ndustry
21215-003	within ne. than "	Completed	Elementary/Secondary (0-12) College (1-4or	5+)	life.	DO NOT use retire	d)	Kiriy		
2	Hygie Hygie other t		12 17. Father's Name (First, Middle, Last)		DRI	VER DISP		ne (First, Middle, M	TAXI	
Maryland	ould be Mental I	To Be	UNKNOWN					UNKN		
ary	shou and M s mar	<b>Ι</b> –	19a. Informant's Name/Relationship (Type, Print)	19	9b. Mailir	ng Address (Street	and Number or Ru		City or Town, State, Zi	p Code)
	and 2 salth a n 27 is		VASILIA VIDI/FRIEND				MANN WA	Y, HIGHLA	ND, MD. 20	777
altimore,	permit. Pages 1 and 2 should be Depertment of Health and Menta important: if item 27 is marked eny injury or other traumatic events.		20a. Method of Disposition 1 □ Burial 2 ▼ Cremation 3 □ Removal from State 4 □ Donation 5 □ Other (Specify)	cemet	tery, crer	sition (Name of natory or other pla	.		Oc. Location - City or T	
Balt	permit. Depertrimporte		21. Signature of Funeral Service Licensee	Ø M000	91 5	Name and Addre CHAMBERS 801 CLEV	ss of Facility FUNERAL ELAND AV	HOME & CR	EMATORIUM, DALE, MD. :	P.A. 20737
			23a. Part1. Enter the disease, or complications that cause shock, or heart failure. List only one cause on each	d the death. Dr						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	5						Onset and Death
	/Medical Examiner		resulting in death)  Due to (or as	s a consequence	e of):					- 1
	a F	Examiner		s a consequenc	e of):					
	uted d ansit		cause. Enter Undertying Cause (Disease or injury that initiated events							
Ö,	cate be executed physician and the burial-transit		and a state of the	s a consequenc	e of):					
8760	cate b	dical	d							
P.O. Box 6	death certiff e attending ed for use as	Physician/Me		e of pregnancy 2 Fetal dea at time of death		Ectopic pregnancy	1		23d. Date of deliv	ery Day Year
	law requires that the as been signed by th 2 should be detache	þ	Part II. Other significant conditions contributing to death	out not resulting	j in the ui	nderlying cause giv	en in Part I.		acco use contribute to	the cause of death?
Division of Vital Records,	0 5 0	Completed	1					24a. Was ar autopsy perform 1 ☐ Yes 2	prior to co ed? death?	opsy findings available ompletion of cause of
<u>ra</u>	ician: Th certificete rector, pag	BeC	25. Was case referred to medical examiner?	11_1112-		10	26. Place of Dea	ath (Check only one		2 No
>	hysic his ce	P.	1 ☐ Yes 2 ☑ No Hospital: Inpati		Dutpatien	t 3 DOA Ott	4   Nursing F	lome 5 Reside	nce 6 Other (Speci	fy)
Ĕ	ling P	i.	27. Manner of Death 28a. Date of Inj Natural 5 ☐ Pending (Month, Da	ury 28b ay Year)	. Time of Injury	Wor		28d. Describe hor	w injury occurred	
NSIC	To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certifical completely filled in by the funeral director.	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined 28e. Place of In building, e	ijury - At home, tc. (Specify)	farm, str	M 1 ==	Yes 2 ☐ No	28f. Location (Str City or Town,	eet and Number or Rur State)	al Route Number.
	pital c		200 Capition 15 Capitaina Charleina Tarkaha		44					
	the Hos	edical	29a. Certifier 1 Certifying Physician: To the best cone one)	of examination a	ge, death and/or in	vestigation, in my o	pinion, death occu	o, and due to the ca arred at the time, da	use(s) and manner as s te and place, and due t	stated. o the cause(s)
	ToT	Σ	29b. Signature and title of certifier	mo	,	29c. Licens			d. Date signed (Month,	
	1+1		30. Name and address of person who completed cause of	doath (Itom 22a	) (Tupo	Drint\	59738		July 7,	D 28852
	Sta	te					cer 100	VE ICER		0 200) 2
#	Registr		JUL 1 1 2006	rar's Signature	Got	W.				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Day JULY 5, 12:30 A M 2006 JOSEPH /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner MONTGOMERY 17720 MILL CREEK DRIVE DERWOOD Birthplace (State or Foreign Country)
 New York 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** 1X M 2 ☐ F Yrs. Director 069-14-9423 85 Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10a. State 10b. County show 10d. Inside City Limits r 28a-f show 1 XYes 2 No Director MD Derwood Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? r than "natural", or Itema 23a or If a Medical Examinar mest be 17720 Mill Creek Drive 20855 U.S.A. filed within 72 hours after death Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2 □ No 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2K No þ If Yes, Give Year or Dates:WWII Specify: Specify: 3 Nidowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) Audio Visual Education Department of Health and Mental High Important: If Item 27 is marked other any injuryor other traumatic event, I once? 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Pages 1 and 2 should be Sophie Knapp Benjamin Macy 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Sona Glickman/Daughter 2896 Glenora Lane Rockville, MD 20852 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☑ Cremation 3 ☑ Removal from State National Crematory 4 ☐ Donation 5 ☐ Other (Specify) 7-7-06 Falls Church, VA 21. Signature of Funeral Service Licensee 23a. Part1. Efter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. EDWARD SAGEL FUNERAL DIRECTION, 1091 ROCKVILLE PIKE, ROCKVILLE, MARYLAND 20852 Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Dehydration /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Osteoporosis Due to (or as a consequence of) Examiner Hospital or Attanding Physician: The law requires that the death certificate be executed -tran Due to (or as a consequence of) nding physicien a use as the burial-P.O. Box 68760, Physician/Medicai attending for use as IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4☐Pregnant at time of death 5 Other (specify) signed by the a d be detached f 9□ Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Division of Vital Records, Arthritis 1 Yes 24 No 3 Probably 4 Unknown Completed Ischemic Heart Disease 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an hes autopsy performed? res 24 No certificate he Depression 1□ Yes After this certification 25. Was case referred to medical 26. Place of Death | Check only one) Other: 4 Nursing Home 5 K Residence 6 Other (Specify) Hospital: 1 XYes 2 □ No 1 Inpatient 2 ER/Outpatient 3 DOA 28c. Injury at Work? 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 Natural 5 Pending Injury within 24 hours after death.

To the Funeral Director: A completely filled in by the fu 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide Medical 29a. Certifier 1 🕱 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. To the 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) meses Humler us D27301 July 5, 2006 20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Douglas R. Shumaker, MD 615 W. Montgomery Ave. Rockville, MD 20850 31. Date filed (Month, Day, Year) 32. Registrar's Signature State 1 1 2006 Registrar

#### 06-05046

Please Type or Print in Black Indelible Ink

00-03040	Flease Type Of Fillic III Black Illuelible lilk
Courtney DeAnne Maith	State of Maryland / Department of Health and Mental Hygiene

		1- For State Certificate of Death	Reg No. (2000)
Physicia	1/	Decedent's Name (First, Middle,Last)	2. Date of Death Month Day Year
Medical Examin		COOKINGI DEANNE MATII	July 14, 2006 1054 nrs
		4a. Facility Name (if not institution, give street and number)  Shady Grove Hospital  4b. City, Town, or Location of De Rockville	eath 4c. County of Death Montgomery
Funeral			Hrs. 8. Date of Birth (MM/DD/YYYYY) 9. Birthplace (State or Foreign
Director	-	214-06-7839 1 M 2XF 22 Yrs. Months Days Hours Musual Residence of Decedent	Mar.14,1984 Country New York
á		10a State 10b County 10c City, Town or Location	10d. Inside City Limits
nd how 2		MD Montgomery Gaithersburg	1 Yes 2X No
Jaryland 28a-f show any 1 at once.	Director	10e. Street and Number 10f. Zip Code	10g. Citizen of What Country?
ith the Maryland 23a or 28a-f sho notified at once.	5	813 Quince Orchard Blvd #21 20878	U.S.A.
with ms 23	e l	11. Marital Status  12. Was Decedent Ever in U.S.  13. Was Decedent of Hispanic Origin?  14. News Married 2. V Married Armed Forces?  15. Was Decedent Ever in U.S.  16. Yes, specify Cuban, Mexican, Pue	( Specify Yes or No- 14. Race - American Indian, Black,
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f she marked other than "natural" and the motified at once	Funeral	1 Never Married 2 Married Armed Forces? If Yes, specify Cuban, Mexican, Pue	D l o el-
s after	ᆈ	Wildowed 4 Divorced in res, Give real of Dates:  1 Yes 2 A No specify:  1 People of the Following (Specificable kindsoft grade completed) 16 People of Level Occupation (Cive kindsoft grade completed) 16 People of the Following Complete Cive kindsoft grade completed (Specificable kindsoft grade completed) 16 People of the Following Complete Cive kindsoft grade co	
2 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)	
0036 within 72 iene ier than '	齓	12th Customer Relation	
5-0( led wi lygien other	ैं		ame (First, Middle, Maiden Surname)
21215-0036 Juld be filed within 7 Mental Hygiene marked other than cevent, the Medica	8		arcella Payne
D 2: should and M 7 is mi	٩ĺ	19a Informant's Name/Relationship (Type, Print)  Rudolph Maith (Husband)  813 Quince Orchan	or Rural Route Number, City or Town, State 70 Cogo 878
e, MD 1 and 2 sho Health and item 27 is	-	20a Method of Disposition 20b. Place of Disposition (Name of cemetery,	rd Blvd. #21, Gaithersburg  Date   20c. Location - City or Town, State
es E		1 Burial 2 X Cremation 3 Removal from State crematory or other place)	7 /07 /06 77 77
Baltimo permit. Pag Department Important: injury or ot	1	4 Donation 5 Other Specify: Metro Funeral Srv   21. Signature of Funeral Service Licensee 22. Name and Address of Facility	7/21/06   Alexandria, VA SNOWDEN FUNERAL HOME, P.A.
Balt permit Depart Impor injury	d	George R. Snowden, Sr. (per DVR) 246 N. Washingt	ton St., Rockville, MD 2085
Physician		23a Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardia failure. List only one cause on each line.	ac or respiratory arrest, shock, or heart Approximate Interval Between Onset and
/Medical Examiner	1	Immediate Cause (Final disease a. Cardiac arrhythmia	Death
		or condition resulting in death)  Due to (or as a consequence of):	
	ē	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):	
	틸	cause. Enter Underlying Cause (Disease or injury that initiated avoids resulting in fastly 1 ast	
ited d d ansit	<u> </u>	events resulting in death) Last Due to (or as a consequence or).  d.	
COUNTY,  9.0. Box 68760,  ires that the death certificate be executed signed by the attending physician and the detached for use as the burial - transit to the detached for use as the burial - transit.	n/Medical Examiner	AMENDED : + confly 220 27 portly COEO 9/	'25 /CC TTT
8760, inficate being physici	Mec	item#21.perFH. 23a.27.perFH.G858.8/	23d Date of delivery
68/ certifi	ian	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pre 4 Pregnant at time of death 5 Other (Specify)	egnancy Month Day Year
Box 6 e death cert the attendii	Physicia	1 Yes 2 No 9 V Unknown 9 Unknown	1
Records, P.O. Box 61 The law requires that the death care has been signed by the attending page 2 should be detached for use a			23e Did tobacco use contribute to the cause of death?
isigne la de de de de de de de de de de de de de	Completed by		1 Yes 2 V No 3 Probably 4 Unknown
Mtd Mtar Records, visician: The law require in scerificate has been si director, page 2 should be	olete		24a Was an autopsy autopsy 24b. Were autopsy findings available prior to completion of cause of
HOMPE (Interpreted icians: The law requirements of secreticate has been rector, page 2 should	E		performed?   death?   1 ✓ Yes 2 No 1 ✓ Yes 2 No
ian:	Bec	25. Was case referred to medical	eck only one)
MCMTCOME In of Vital Records in Physician The law requirements certificate has been unertal director, page 2 should	2	1 V Yes 2 No Inpatient 2 Produpatient 3 DOA 4 No	ursing Home 5 Residence 6 Other.
n of a of ding P			28d. Describe how injury occurred
Division tal or Attendii rs after death al Director: A led in by the fu	cati	2 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc.	28f. Location (Street and Number or Rural Route Number, City
Divisor A all Direction by	ertification:	3 Suicide 6 Could not be determined (Specify)	or Town, State)
Divis  Bivis  Hospital or A 24 hours after Funeral Directely filled in b	ပ	20a Certifier	and due to the cause(s) and manner as started.
Division of Vital Records.  To the Hospital or Attending Physician: The law requirement of the Puneral Director: After this certificate has been completely filled in by the funeral director, page 2 should	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated	red at the time, date and place, and due to the cause(s)
F % F S	Me	29b Signature and title of certifier 29c. License number	29d Date signed (Month, Day, Year)
		Udyone The yorld O.C.M.E.	July 15, 2006
	8	30. Name and ad ress of person who completed cause of death (Item 23a)	MD 21201
	- 15	Margarita Korell MD. Assistant Medical Examiner 111 Penn Street, Baltimore, M  31. Date filed (Month Day Year) 33. Registrar's Signalue	ND 21201
St Regist	ate rar	111 19 11 711115 1844 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	

			For State Registrar	State of Ma	aryland		artmen rtificate			and M	•	giene Reg. No.	06	23398
	Physici	an	1. Decedent's Name (First, Middle, La MARGARET		015	.14			·		2. Date of De Month	Day	Year	3. Time of Death
	/Medic		4a. Facility Name (If not institution, give		1212	717	4h City	Town or	Location of	of Death	July	4c Coun	200 (c	<u> </u>
1	Examin	er	ANNE ARUNDAL		CEN	STER			001				•	UNDAL
	Funeral		5. Social Security Number 6. 5	Sex 7. Age		ast birthday)	If Under	1 Year	If Under	24 Hrs.	8. Date of Bir		9 Birth	place (State or Foreign
	Director		214-46-65/9	1□M 27万F	60	Yrs.	Months	Days	Hours	Min.	8. Date of Bir (Month, Da Feb. 7	, 1946	MD	nury)
	put .		Usual Residence of Decedent  10a. State 10b. County	-	10c. City	, Town or Lo	veation							10d. Inside City Limits
	Aaryli r sho	ច	MD Anne Ar	unde1		mbril								1 XYes 2 No
	28e-	Funeral Director	10e. Street and Number				10f. Zip	Code				10g. Citizen o	f What Cou	entry?
	3a or	i Di	1846 Russell Roa	d			2	1054				USA		•
	deatl	ner	11. Marital Status	12. Was Decedent E Armed Forces?	Ever in U.S	3. 13.			spanic Orig	gin? (Spe	ecify Yes or No Rican, etc.)	)- 14. Ra	ace - Ameri	
ဖွ	or Ite	/Fu	1 ☐ Never Married 2 ☐ Married	1 Tes 2 X	lo	1	1 ☐ Yes :		Specify:	i, Fuerto	nican, etc.)	Spec	ack, White,	ite
Ö	72 hours after death with the Maryland naturel', or Items 23a or 28e-f show lites! Examinar must be molified at	d by	3 ☐ Widowed 4 🎇 Divorced	Year or Dates:										
<del>1</del> 5-	in 72	Completed	15. Decedent's E (Specify only highest gr	ade completed)		16a. Dece (Give life.	dent's Usua kind of wor DO NOT us	rk done a	luring most	t of worki	ing	16b. Kind of	Business/In	ndustry
12	with iene.	шо	Elementary/Secondary (0-12)	College (1-4or 5		Depar				se		US G	overn	ment
b	e filec Hyg othe Vent,	BeC	17. Father's Name (First, Middle, Last	)					18. Mothe	r's Name	(First, Middle,	Maiden Suma	ıme)	
/lar	Menta	ToE	Nathan Perry Co	oksey					E11	en R	idgley	Sweene	У	
Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importent: If Item 27 is marked other then "naturel; or Items 23a or 28e-f show any rightry or other treumatic event, the Medical Examinat must be notified at an ance.		19a. Informant's Name/Relationship								I Route Number	_	n, State, Zij	o Code)
ē,	l and fealth em 27 her tr		John E. Mandish	11/ Son	20h Bi	1809 ace of Dispo			ne C		on, MD	21114	Observa	
Baltimore,	ages intoff inter inter		20a. Method of Disposition  1 Burial 2 XCremation 3		ce	metery, crer	natory or o	ther place				20c. Location	orf,	
Eir	it. Partmer rtent rtent njury		<ul> <li>4 □ Donation 5 □ Other (Special Signature of Funeral Service Lice</li> </ul>	-	Hun			•			/2006			
Ba	Department of the control of the con		> KANK	1		# "	16000	Ann	apoli	'Rob s Ro	ert E. ad Bov	Evans vie. MD	Funer 207	al Home
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	Pnysician		shock, or heart failure. List only Immediate Cause (Final			: )	110		20 =	C T				Interval Between Onset and Death
	/Medical		disease or condition resulting in death)	a CARD Due to (or as			OAIC	A	icice.	2			-	1 hour
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687	death certificate be executed e attending physician and nd for use as the burial-transit	edicai		_ d.										
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P.0.	that the de ned by the a detached f	hys	9 🗆 Unknown	9∐ Unknown							1			
	b or	by	Part II. Other significant conditions					ause give	n in Part I.		-		_ /	he cause of death?
ord	w requir been si should	Completed	E22EN	FIAL THE	ZOMI	12021	2				101	res 2□No	3 Prot	oabły 4 ∐Unknown
3ec	9 2 9	mpie									24a. Was autop		. Were auto prior to co death?	opsy findings available impletion of cause of
alF	Th ate pag										1 ☐ Yes	2 No		2 No
Vit	Physicien: r this certifica ral director, I	o Be	25. Was case referred to medical examiner? 1 ☐ Yes 2 ☒ No	Hospital:		R/Outpatien	t 3[] DO	Othe			(Check only o			
Division of Vital Records,	g Phy er this	n; To	27. Manner of Death	28a. Date of Injur	v :	28b. Time of		8c. Injury Work	at Nu		me 5 ☐ Resid 28d. Describe h			(y)
ion	ath. r: Aft	atio	1 Natural 5 Pending 2 Accident investigation	(Month, Day	rear)	Injury	М		r ′es 2 □ ì	No				
<u>N</u>	el or Attending F s after death. I Director: After d in by the funer	Certification;	3 Suicide 6 Could not be determined				eet, factory	, office		1	28f. Location (5 City or Tox		ber or Rura	al Route Number,
	itel o rrs aft rel Di													
	Hosp 4 hou Fune tely fil	edical	(Check only 2 Medical Exa	nysician: To the best on miner: On the basis of	examinati	vledge, death on and/or in	n occurred a vestigation,	at the tim in my op	e, date and inion, deat	d place, a	and due to the	cause(s) and m date and place	nanner as s , and due to	tated. o the cause(s)
	To the Hospitel or Attending Physicien: within 24 hours after death.  To the Funerel Director After this certific completely filled in by the funeral director,	Med	one) 29b. Signature and title of certifier	and manner sta	TOO.			License				29d. Date sign		
)	T W T S		Dall with.	Lee MO			200		306	1881		7   7		
7			30. Name and address of person who		ath (Item	23a) (Tvne	Print)					, 1 1 1	acci	<i>U</i>
			HEATHER LEE ,					5 50	TE	Α.	BOWI	EMD	20-	115
	Sta	te	31. Date filed (Month, Day, Year)	Registra			M.				5411	- 4 - 1/	V	
	Registr	ar	JUL 1 0 20	Ub Allen	15	1373								

		ľ	1 - For State Registrar	State of Mary	-	artment of Hertificate of L		ental Hygiei Reg.		2 0 0 11
	Physici /Medic Examir	cal	1. Decedent's Name (First, Middle, MAX BE 4a. Facility Name (If not institution, g	ive street and number)	LLER	4b. City, Town, or CHESTE	Location of Death	JULY ,	Day Year 12 200 4c. County of Dea	
	Funeral Director		5. Social Security Number 6 154–14–2406  Usual Residence of Decedent		yrs. last birthday) 91 Yrs.	If Under 1 Year Months Days		B. Date of Birth (Month, Day, Ye AY 2, 19		thplace (State or Foreign ountry) IL
	ith the Maryland or 28a-f show	Director	10a. State 10b. County MD KENT  10e. Street and Number		c. City, Town or Lo	COWN  10f. Zip Code			Citizen of What C	10d. Inside City Limits 1X☐ Yes 2 ☐ No ountry?
980	within 72 hours after death with the Maryland ene. then "naturel", or items 23e or 28a-f show the Medicul Examiner must be recified at	Completed by Funeral Director	315 HERON POIN  11. Marital Status  1 Never Married 2 Married  3 Xwidowed 4 Divorced	12. Was Decedent Ever Armed Forces?		21620  Was Decedent of His f Yes, specify Cubar 1 Yes 2 X No	Spanic Origin? (Specin, Mexican, Puerto Ri	fv Yes or No-	SA  14. Race - Ame Black, Whith	
121215-0036	s 1 and 2 should be filed within 72 hours Health and Mental Hygiene. Item 27 Is marked other then "naturel", other treumetic event, the Medical Era		15. Decedent's (Specify only highest s Elementary/Secondary (0-12)	College (1-4or 5+)	(Give life. I	STRIAL CHI	luring most of working ) EMIST	C	Kind of Business	/Industry
Maryland	2 should be filed within and Mental Hygiene. Is marked other then "reumetic event, I to Me.	To Be	17. Father's Name (First, Middle, La  ALBERT F. MUEI  19a. Informant's Name/Relationship	LER  (Type, Print)		ng Address (Street a	18. Mother's Name ( LETA BEST and Number or Rural I	Route Number, Cit	ty or Town, State,	Zip Code)
Baltimore, M	e = 5		JOHN MUELLER/SON  20a. Method of Disposition  1 □ Burial 2 🖫 Cremation 3  4 □ Donation 5 □ Other (Spe	Removal from State	0b. Place of Dispo		RD, ROCHES ORY 07/13		. Location - City or	
Balti	permit. Pa Departmer Importent eny injury		21. Signature of Funeral Service Lic	Helpube			ELFENBEIN ROAD, CHES		FUNERAL MD 2162	
8760,	Physician and // Medical Examiner physician and physician and physician is the physician in the physician in the physician phy	dical Examiner	23a. Part1. Enter the disease, or or shock, or heart failure. List on immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. CENEB  Due to (or as a co	ROVAS insequence of): ENSTON insequence of).	CULAR		DENT		Approximate Interval Between Onset and Death SWOOD West >15 Year
Box 6	The law requires that the death certificate be executed as been signed by the attending physician and cage 2 should be detached for use as the burial-transit	Physician/Medic	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome of p 1 □ Live birth 2 □ 4 □ Pregnant at time 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date of de Month	ivery Day Year
ords, P.O.	w requires that t been signed by should be deta		Part II. Other significant conditions PANOX YSM AC		_	, ,	n in Part I.		. 1	the cause of death?
of Vital Records,		e Completed by	25. Was case referred to medical				OC Blace of Dooth (	24a. Was an autopsy performed	? death?	utopsy findings available completion of cause of 200 No
Division of Vit	ding Phys	Certification: To Be	25. Was case referred to medical examiner?  1 Yes 25 No  27. Manner of Death  1 Natural 5 Pending investigat  2 Accident investigat  3 Suicide 6 Could not determine	be 290 Place of Injury	At home, farm, stre	Othe	at 28	5 Residence	njury occurred  and Number or Ri	cify) ural Route Number,
1	To the Hospitel or Attent within 24 hours after death To the Funerel Director: completely filled in by the	Medical Ce	29a. Certifier (Check only one)  1 Certifying 2 Medicel Ex	Physicien: To the best of my eminer: On the basis of exa and manner stated.	y knowledge, death mination and/or inv	occurred at the time restigation, in my op	inion, death occurred	at the time, date a	o(s) and manner as and place, and due Date signed (Mont	to the cause(s)
)	E M M		> Am	A Mhe	mo		41587	1	12/2	006

State Registrar

HELEN NOBLE 31. Date filed (Month, Day, Year)

DHMH 17 Rev 1/2001

ORIGINAL

MD, 122SPEER RD, CHESTERIONN MD 21620

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Month **Physician** Mary Ruth Montgomery 29, 2006 June /Medical 4a. Fecility Neme (If not institution, give street and number) 4b. City, Town, or Location of Deeth 4c. County of Death Examiner SunBridge Care & Rehabilitation Elkton Cecil 5. Social Security Number Year If Under 24 Hrs. Birthplace (State or Foreign Country)
 MD 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Dey, Yeer) Hours 1 □ M 2 😾 F 199-05-8420 84 04-27-22 Baltimore Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits MD Baltimore YYes 2 No Director Baltimore City

10f. Zip Code

21225

Was Dacedent of Hispenic Origin? (Specify Yes or No-If Yes, specify Cuben, Mexican, Puerto Rican, etc.)

10g. Citizen of What Country?

29d. Date signed (Month, Dey, Year)

06

14. Rece - American Indian, Black, White, etc.

7.7 la 4 4 a

U.S.A.

Director

10e Street and Number

11. Maritel Status

512 Baltic Avenue

1 Nevar Married 2 Merried

12. Was Decedent Ever in U.S. Armed Forces?

1 Yes XXNo

**Funeral** 

death with the Maryland permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or Items 23a or 28a-f show any injury or other traumatic event, the Madical Examinat must be notified at

Baltimore, Maryland 21215-0036

Pnysicial /Medica Examine

To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death, To the Funeral Director: Al completely filled in by the fu

Division of Vital Records, P.O. Box 68760,

		- ACOUNT
		23a. Pert1. Enter the disease, or c shock, or heert failure. List of
		Immediate Cause (Final disease or condition resulting in death)
	cal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last
	Be Completed by Physiclan/Medical Examiner	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yas 2 ☑ No 9 ☐ Unknown
1	ted by P	Part II. Other significant condition
	mple	
	ပိ	
		25. Was case referred to medical examiner?  1 ☐ Yes 2 No
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	edical	29a. Certifiar (Check only one) Certifying 2 Medicel E
	Σ	29b. Signature and title of certifier

ģ	<b>3</b> ∰Vidowed 4 □ Divorced	Year or Detes:		1 Li Yes 2124 No	Specify:		Spec	oify: WIII	Le
To Be Completed by	15. Decedent's Ed (Specify only highest gra	ide completed)	16e. Dece (Give	dent's Usuel Occu	pation during most of wo	orking	16b. Kind of	Business/Indust	ry
E O	Elementary/Secondary (0-12)	College (1-4or 5+)		Homemak			omes	tic/Own	n Home
9	17. Father's Name (First, Middle, Last,	)			18. Mother's Na	me (First, Middle, M	feiden Suma	ame)	
To B	John Bernard				Rose	Soustik			
	19a. Informant's Name/Relationship ( Mary E. Kohler					ural Route Number, Middlet			9709
	20a. Method of Disposition 1 ☐ Burial 2€ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification)	Removal from State	ametery, crei	osition (Name of matory or other pla Cremate	ory 06/	1	oc. Location	n - City or Town,  DE	State
	21. Signature of Funeral Service Liber	tabt	D <i>I</i> 21	2 N Bro	& HUTCH:	ISON FUN	n DE	HOME 19709	
	23a. Pert1. Enter the disease, or com shock, or heert failure. List only Immediate Cause (Final	plications that ceused the death one cause on each line	. Do not ent	er the mode of dy	ng, such as cerdia	c or respiratory arre	st,	Inte	proximate erval Between set and Death
	disease or condition resulting in death)	a LO(0)	( an	con i	metas	tasis			
	Todaking in dockin	Due to (or as e consequ							
_	Sequentially list conditions,	b		Cancer					
amine	if any, leading to immediate cause. Enter Underlying Cause (Disease or Injury that initiated events resulting in death) Last	v	uce	disord	lee				
Physician/Medical Examiner	locality cast	d. Due to (or as a consequence of the consequence o			·				
an/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnal		Ectopic pregnanc			23d. D	ate of delivery	
ysicle	in the past 12 months? 1 □ Yas 2 ☒ No 9 □ Unknown	4☐Pregnant at time of de		Other (specify)	у		M	Month Day	Year
y P	Part II. Other significant conditions c	ontributing to death but not resu	lting in the u	nderlying cause gi	ven in Part I.	23e. Did tob	acco use cor	ntribute to the ca	use of death?
ed b						1 🗀 Yes	2 □ No	3 🗌 Probably	4 Unknow
Completed by						24a. Was an autopsy perform		. Were autopsy f prior to complet death? 1 \( \text{Yes} \) 2 \( \text{Square} \)	tion of cause of
Re	25. Was case referred to medical examiner?				26. Place of Dea	ath (Check only one	)		
0	1 ☐ Yes 2 No	Hospital: 1 ☐ Inpatient 2 ☐ I	ER/Outpatien	it 3 DOA Ot	ner: 4 Nursing H	łoma 5 ☐ Resider	ice 6 🗆 Ot	ther (Specify)	
ion:	27. Manner of Death  Natural 5 Pending	28a. Date of Injury (Month, Dey Yeer)	28b. Time of Injury	Wo	rk?	28d. Describe how	v injury occu	irred	
ertification:	2 Accident investigetion 3 Suicide 6 Could not be 4 Homicida determined		me, farm, str		Yes 2 □ No	28f. Location (Stre City or Town,	et and Num State)	nber or Rural Rou	ute Number,

Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.

29c. License number

D0063720

DHMH 17 Rev 1/2001

State Registrar 118 North

me and address of person who completed cause of death (Item 23a) (Type, Print)

32. Registra Signature

Visani

31. Date filed (Month, Day, Yeer)

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - Stata Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** 2006 Arlene MacDonald-Myers July 07 5:00 p <sup>M</sup> /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner 463 East Green Street Carroll Westminster If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Sept 02 1927 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Months 1 □ M 2 🔀 F Yrs. Director 78 219-20-4001 Usuet Residence of Decedent the Maryland Pages 1 and 2 should be filed within 72 hours after death with the Marylan ment of Heatth and Mental Hygiene.
ant: If item 27 ie marked other then "neturet", or items 23a or 28a-f ehow ury or other traumatic event, the Madical Expender must be notified at 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Carroll Westminster Director 1 XYes 2 No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 463 East Green Street 21157 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 White 1 Yes 2 No Specify: þ Specify. 3 ☐ Widowed 4 ☐ Divorced Year or Dates: Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) 12 Food Service Director Western MD College 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be Walter Hersh Hilda Barnhart 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 619 Woodside Drive Westminster, MD Carol Kelly/daughter 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 07/11/2006 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State permit. Page Department of Important: If eny injury or Bixlers Church Cemetery Westminster, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Fundal Service Lic. Pritts Funeral Home and Chapel, P.A. 412 Washington Road Westminster, MD 21157 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Finat API **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner use as the burial-transit certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): physicien Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 Yes 2 No 23d. Date of delivery 3 Ectopic pregnancy ò Month Day Year 4 Pregnant at time of death 5 Other (specify) P.0. detached 9 Unknown 9 Unknown à Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. page 2 should be 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy lindings available prior to completion of cause of death? The law 24a. Was an certificate has autopsy performed? 2 No 1 ☐ Yes 2 ☐ No 1 🗆 Yes To the Hospitel or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 sidence 6 Other (Specify) ၉ 1 ☐ Yes 2 ☐ No 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) After the 28b. Time of 27. Manner of Death Certification: 28c. Injury at Work? 28d. Describe how injury occurred 1 Naturat 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Ptace of Injury - At home, larm, street, lactory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) WIL 10 Name and I ddress of person who completed cause of death (Item 23a) (Type, Print) 555South Couter Street Westminister, MD 21157 Invio hruter

Registrar

State

31. Date filed (Month, Day, Year)

1 0 2006

32. Registrar's Signature

06-04870 Otis Junior Miller

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certi	ficate of D	eath		F	Reg. No.	200	6 2351
Physici		1. Decedent's Name (First, Midd	lle,Last)					2. Date of Dea	ath		3. Time of Death
Medical Exami	ner	Otis	Jun:	ior		Mi	ller	July 9, 20	Day \	/ear	0912 hrs
		4a Facility Name (if not institution	on, give street and number)		4b.	City, Town,	or Location of Dea			ty of Death	1
		Memorial Hospital				umberlai	nd		Allega	ny	
Funeral		5. Social Security Number	6. Sex 7. Age	e (In yrs. last		f Under 1 Ye			irth (MM/DD/YY	YY) 9 Bir	thplace (State or
Director		214-28-6447	1 X M 2 F	73	Yrs	Months Da	ays Hours N	1in. 06/02	/1033	Co	Maryland
		Usual Residence of Decedent						100/02	7 1933		
, any		10a. State 10b. County		10c. City, To	own or Location	-					10d. Inside City Limits
und shov	ъ	MD A	llegany		Cu	mberla	and				1 X Yes 2 No
Maryland 28a-f show	Director	10e. Street and Number				of. Zip Code			10g. Citizen of	What Cour	ntry?
ith the Maryland 23a or 28a-f sho notified at once.		517 Furna	ce Street				2150	02		USA	
215-0036  be filed within 72 hours after death with the Maryland nnal Hygiene rked other than "natural", or items 23a or 28a-f she ent, the Medical Examiner must be notified at once	Funeral	11. Marital Status	12. Was Decedent	Ever in U.S	13. Was De	ecedent of H	Ispanic Origin? (	Specify Yes or No	D- 14. Ra	ce - Ameri	can Indian, 8lack,
death r iter	nu	1 Never Married 2 X M	larried Armed Forces?	No	If Yes,	specify Cuba	an, Mexican, Puer	to Rican, etc )		nite, etc	
offer of per n		3 Widowed 4 Div	vorced If Yes, Give Year or Dates: 1952-		1 Ye	s 2 <b>y</b> N	o specify.		Specify	/ T.71	a ÷ 4 a
ours a	d by	15. Decedent's Education (Spe	cify only highest grade com	pleted) 16			ation (Give kind o		16b. Kind of		nite
72 h	Completed	Elementary/Secondary (0-12)	College (1-4 or 5	+)	during most	of working lif	e. DO NOT use re	etired)			
030	ш	12			Custo	odian			Publi	c Sch	nools
15-003 Tled withir Hygiene d other th		17. Father's Name (First, Middle	, Last)				18.Mother's Nar	ne (First, Middle,	Maiden Surnan	ne)	-
21215-0036 July be filed within 72 hours a Menal Hygiene marked other than "natura e event, the Medical Examin	Be	Otis	0scar		Miller		Annie	V.	iola	Dee	etz
	ို	19a. Informant's Name/Relations			19b. Mailing Ad	dress (Stre	et and <b>N</b> umber o	r Rural Route Nur	mber, City or To	own, State,	Zip Code)
ore, MD 2 es 1 and 2 shou of Health and 1 friem 27 is r her traumatie		Norma J. Miller	c / wife		517 Ft	ırnace	Street	Cumber	land, M	ID 21	1502
Fe, s I ar if Hec If ite		20a, Method of Disposition  1 XBurial 2 Cremation	2 Removed from Ste		ce of Disposition		emetery,	Date	20c. Location	n - City or	Town, State
imore, MD 2 Pages I and 2 shou ment of Health and N ant: If item 27 is n or other traumatie		4 Donation 5 Other S	time and		et. Cem	@ Roc	ky Gan (	7/12/20	6 Fli	ntata	no MD
Baltimore, I permit Pages I and Department of Heal Important: If item injury or other tra		21. Signature of Funeral Service	Licensee		22. Name	and Addres	ss of Facility A	lams Fam	ily Fun	eral	one, MD Home, P.A.
<b>a</b> §9 <b>a</b>		Kulet C.	Jalu )		404	Decat	ur Stree	et. Cumbe	erland.	MD	21502
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/Medical Examiner		Immediate Cause (Final disease									Between Onset and Death
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Manager "		Sequentially list conditions,	b								
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tal Rec cian: The certificate ector, page	ø	25. Was case referred to medica				26.Plac	e of Death (Check	( only one)			
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ivisior or Attenc after death Director:	ijΞ		d not be 28e. Place of Inju	ıry - At home	e, farm, street, fa	ctory, office	building, etc.			per or Rura	al Route Number, City
Divi	Certification:		rmined (Specify) Majo	or Road /	Highway			or Town, S Burger King	<sup>tate)</sup> Intersection	n. Natior	nal HWY, Lavale,
Host 24 hc Func xely f		29a. Certifler 1 Certifying Pt	nysician: To the best of my	knowledge,	death occurred a	at the time, d	ate and place, an	d due to the cause	e(s) and manne	er as starte	d
Division of Vital Records, P.O. Box 68760, To the Hospital or Atending Physician: The law requires that the death certificate be within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending physici completely filled in by the funeral director, page 2 should be detached for use as the buri	edical	one) 2 Medical Exa	miner: On the basis of exam and manner stated	ination and/o	or investigation,	n my opinior	n, death occurred	at the time, date a	and place, and	due to the	cause(s)
(5) NVC	Me	29b. Signature and title of certifie				29c Licens	se number		29d. Date sigi	ned (Mont	h, Day, Year)
Sic		(dust)				O.C.	M.E.		July 10, 20	006	
, VA	}	30. Name and address of person	who completed cause of de	ath (Item 23	a)						
•			istant Medical Exami	,	'	et, Baltim	ore, MD 2120	1			
Sta	ate	31. Date filed (Month, Day, Year)	32 Registrar's					<u> </u>			
Regist	_		(2)	· Fin	and the co						

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month Earl Glydon Miller July 07, 2006 06:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 10126 Piney Mountain Road, S.W. Allegany Frostburg If Under 1 Year If Under 24 Hrs. 5. Social Security Number 8. Date of Birth (Month, Day, Year) 17-Feb-1936 7. Age (In yrs. last birthday) Funeral 9. Birthplace (State or Foreign 10 M 2□ F Days Hours Min. Months 220-34-2170 70 Yrs. Director Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic event, the Medical Evantract rives be notified at 10d. Inside City Limits Maryland Allegany Frostburg Director 1 Yes 2 No 10e. Street and Number 10126 Piney Mountain Road, S.W. 10f. Zip Code 10g. Citizen of What Country? 21532-U.S.A. 2 should be filed within 72 hours after death in and Mental Hygiene. by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 M No If Yes, Give Year or Dates: 11. Marital Status Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puento Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 Yes 2 No 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation 15. Decedent's Education 16b. Kind of Business/Industry (Specify only highest grade completed) (Give kind of work done di life. DO NOT use retired) ring most of working Elementary/Secondary (0-12) College (1-4or 5+) housekeeping department state government 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Earl Robert Miller Elizabeth B. A. Jones 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) permit. Pages 1 and 2 sh Department of Health and Important: If item 27 Is rr any injury or other traum <u>2005e.</u> Edgar Miller 10046 Piney Mountain son Frostburg Maryland 21532 20b. Place of Disposition (Name of 20a. Method of Disposition Date 20c. Location - City or Town, State cemetery, crematory or other place) Burial 2 Cremation 3 Removal from State Frostburg Memorial Park 12-Jul-2006 Frostburg 4 ☐ Donation 5 ☐ Other (Specify) Maryland 21. Signature of Funeral Service License 22. Name and Address of Facility Durst Funeral Home, 57 Frost Ave., Frostburg, MD 21532 23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** O YOMY /Medical Due to (or as a consequence of): **Examiner** Sequentially list conditions, Dire to (or as a consequence of) Examiner cause. Enter Underlying Cause (Disease or injury The law requires that the death certificate be executed burial-transit that initiated events resulting in death) Last Due to (or as a consequence of) the attending physician thed for use as the burial Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 No 4☐Pregnant at time of death Month Day Year 5 Other (specify) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 3 Probably 1 ☐ Yes 2 ☐ No 4 Onknown Completed 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed 2 🛮 1 Yes 2 No Hospital or Attending Physician: 25. Was case referred to medical 26. Place of Death (Check only one examiner' Other: 1 ☐ Yes 2 🔭 No 1 Inpatient 2 ER/Outpatient 3 DOA 4 Nursing Home 5 Desidence 6 □Other (Specify) this funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? Certification: 28d. Describe how injury occurred After Injury 1 Matural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours after death To the Funeral Director: 6 Could not be determined 3 TSuicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 29a. Certifier 🔯 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medicel Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) To the 29b. Signature and title 29d. Date signed (Month, Day, Year) 10 completed cause of death (Item 23a) (Type, Print) 30. Name and address of person who DRIVE CUMBURLAND MD 21502 NOB 07 32. Registrar's Signature 31. Date filed (Month, Day, State 200 Registrar

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	Physic	an	1. Decedent's Name (First, Middle,	Last)							2. Date of De	aath Day	Year	3. Time	e of Death
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Division	r Attender death	<u>≅</u>	3 ☐ Suicide 6 ☐ Could not	d   286. Place	of Injury - At h	nome, farm, stre	et, factory,	office		21	Bl. Location (S	treet and Nu	ım <i>ber or R</i> u	al Route Nu	m <i>ber</i> .
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	bours hours unera ly fille		29a. Certifier 1 Certifying F	hysician: To the I	best of my kn	owledge, death	occurred a	t the time	, date and	place, ar	nd due to the o	ause(s) and	manner as	stated.	-
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	Mas		30. Name and address of person with							_		=			
	-		JOS T. HOV  31. Date filed (Month, Day, Year)	eria, M.	D., 9 vistrar's Signa	12 Seto	n Dri	ve,	Cumbe	rlan	id, MD	21502	2		
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		1	For State Registrar	State of M	laryland		rtment of H		nd Menta		ne .No.2 0 0 6	23405
	Physicia	100	1. Decedent's Name (First, Middle, Las	ı) aran					Mo	e of Death	Day Year	3. Time of Death 6:30 P M
* **	/Medic Examin	A	4a. Facility Name (If not institution, give	street and number			4b. City, Town, or Chevy Ch	ase	Death		4c. County of Dea Montgome	ry
	Funeral Director		212-08-3456	7. A	ge (In yrs. Ias 33	Yrs.	If Under 1 Year Months Days		Min (Mo	e of Birth nth, Day, Yo • 18,	ear)   C	thplace (State or Foreign ountry) hington, D.C
	Maryland a-f ehow	tor	Usual Residence of Decedent           10a. State         10b. County           Maryland         Montgomet	cy	,	Town or Lo						10d. Inside City Limits 1 ☐ Yes 2 No
	with the	I Direc	10e. Street and Number 3414 Turner Lane			<u>-                                    </u>	10f. Zip Code 20815			US.	. Citizen of What C A	ountry?
36	s after death , or iteme 2	by Funeral Directo	11. Marital Status  1X Never Married 2  Married 3  Widowed 4  Divorced	12. Was Deceden Armed Forces 1 □ Yes 2X If Yes, Give Year or Dates:	? ]No	l l	Vas Decedent of Hi f Yes, specify Cuba	spanic Origir n, Mexican, I Specify:	n? (Specify Ye Puerto Rican, o	s or No- etc.)	14. Race - Am Black, Whi Specify: Wh	te, etc.
9500-61212	filed within 72 hours atter death with the Maryland Hygiene. kther than "natural", or Iteme 23a or 28a-f ehow sht, the Medical Examinat mutt be notified at	Completed b	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation	5+)	(Give life. L	lent's Usual Occupa kind of work done o DO NOT use retired	during most o	of working		b. Kind of Business	/industry
	be filed withir ital Hygiene. Id other than event, the Mi	Be Con	17. Father's Name (First, Middle, Last)	4		Music					ntertainn iden Sumame)	nent
Maryland	2 should and Men is marks	Tof	Stephen Paul Mara: 19a. Informant's Name/Relationship ( Stephen P. Maran/	Type, Print)					or Rural Route		City or Town, State,	Zip Code)
	ages 1 and 2 nt of Health I: If Item 27 i		20a. Method of Disposition 1 Burial 2 Cremation 3	Removal from State	20b. Pla	ce of Dispo	sition (Name of natory or other place	(9)	Date	20	c. Location - City or	rTown, State Maryland
Baltimore,	permit. Pages Department of h Important: If Its any injury or of		4 Donation 5 Other (Specification 21. Signature of Funeral Service Licentary Control of Funeral Service Control of Funeral Service Licentary Control of Funeral Service Control		/	22 G	Name and Address	s of Facility	ation S	ervic	e P.O. E	
8760,	death certificate be executed (Medical Examiner and Idea as the burial-transit	Ilcal Examiner	23a. Part1. Enter the disease, or com shock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	a. Primary Due to (or a	ine.	al Ne ence of):						Approximate Interval Between Onset and Death 3 1/2 years
.O. Box 6		Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	23c. If yes, outcom  1 Live birth  4 Pregnant 9 Unknown	2 Fetal d	leath 3	Ectopic pregnancy Other (specify)	,			23d. Date of de Month	elivery Day Year
0	uires that t r signed by ild be detac	by	Part II. Other significent conditions of	ontributing to death	but not result	ting in the u	nderlying cause giv	en in Part I.	23			to the cause of death?  Probably 4 □Unknown
Records,	The law requires that the ate has been signed by the page 2 should be detache	Completed								a. Was an autopsy performe ] Yes 2	prior to	autopsy findings available completion of cause of s
Vita	Physician: The ribis certificate hiral director, page	Be	25. Was case referred to medical examiner?  1 Yes 2X No	Hospital: 1 □ Inpa	tiont 2DE	P/Outnation	nt 3□ DOA Oth		of Death (Chec		ce 6 □Other (Spi	acifu)
Division of Vital	ding Ph h. After th tuneral	atlon: To	1 ☐ Yes 2X No  27. Manner of Death  1X Natural 5 ☐ Pending 2 ☐ Accident investigation	28a. Date of in (Month, D	ijury 2	28b. Time of Injury	f 28c. Injur Wor	y at	28d. De		injury occurred	outy)
Divis		Certification:	3 ☐ Suicide 6 ☐ Could not be determined	289. Flace 011	njury - At horr etc. <i>(Specify)</i>		reet, factory, office			cation (Streety or Town,		Rural Route Number,
	To the Hospital or within 24 hours after To the Funerel Dir completely tilled in	Medical	29a. Certifier Check only one) Check only 2 Medical Example 1	nysicien: To the bes niner: On the basis and manner	of examination	ledge, deat on and/or in	h occurred at the tin vestigation, in my o	ne, date and pinion, death	place, and due occurred at the	e to the cau ne time, date	se(s) and manner a e and place, and du	as stated. re to the cause(s)
	To the Within To the	Me	29b. Signature and title of certifier	1/2	1		29c. Licens D433				I. Date signed (Mor	
6	12		30. Name and address of person who				Print)				1y 10, 20	
	St	ate	Robert S. Siegel, 31. Date filed (Month, Day, Year)	32. R gis	strar's Signatu	ıre		. NW I	Washing	ton,	D.C. 2003	3 /
70	Regist	rar	JUL 1 2 2	UUD JU	we s	J. A	Devis					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) July 5, <sup>Day</sup> 2006 **Physician** Marie Virginia Nicholson 7:28 P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Anne Arundel Annapolis Anne Arundel Medical Center If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 8. Date of Birth (Month, Day, Year) **Funeral** 1 □ M 2 💢 F Yrs. Director 578-42-5453 3/29/1933 New York Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits show item 27 is marked other than "natural", or items 23a or 28a-f show other traumatic svent, it a Modical Examinar must be notified at 1 ☐ Yes 2 No Anne Arundel Annapolis Director Maryland 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21401 1147 Riverview Drive death Funeral 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 📆 No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 X No Specify: White Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Construction 12th Time Keeper 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Parscondola Odella Deck Mary Pasquale 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1147 Riverview Dr., Annapolis, MD 21401 Benjamin T. Nicholson, Jr. / Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Date 20a. Method of Disposition permit. Pages 1
Department of H
Important: If ite
any injury or ot 1) Purial 2 □ Cremation 3 □ Removal from State MD Veterans Cemetery | 7-10-06 Crownsville, MD \*4 □ Donation 5 □ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine attending physicien and for use as the burial-transit death certificate be executed Due to (or as a consequence of): Records, P.O. Box 68760. Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 proofths?

1 Yes 2 No
9 Unknown been signed by the atte should be detached for Month Day 4☐Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Inknown YIL 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 24a. Was an page 2 s has autopsy performed? Yes 2 21344 1 🗌 Yes Division of Vital or Attending Physician: 25. Was case referred to medical examiner? the funeral director, Be 26. Place of Death (Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 No 1 Dippatient 2 ER/Outpatient 3□ DOA this 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 27. Manner of Death 28c. Injury at Work? After t 5 Pending investigation 1 Natural after death. 1 ☐ Yes 2 ☐ No 2 Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) To the Hospital or Atte within 24 hours after de To the Funeral Directo completely filled in by the 4 Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Exeminer: Op the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29d. Dale signed (Month, Day, Year) 29b. Signature and tiple of certifier 29c. License number 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 1600 Que 31. Date filed (Month, Day, Year)

JUL 1 0 2006 egistrar's Signatu State Registrar

State of Maryland / Department of Health and Mental Hygiene 23407 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day **Physician** TIMONTH 2 2ďď6 REGEAN B. OWENS 11:13 AM /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner CHESTER RIVER HOSPITAL CENTER KENT CHESTERTOWN If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth Month Day Year 09/20/1931 **Funeral** 1 ☐ M 2 💢 F 74 214-28-3114 Yrs PA Director Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location 10d. Inside City Limits Worle notified at 1 ☐ Yes 21 No MD Directo KENT BETTERTON 10e. Street and Number 10f. Zin Code 10g. Citizen of What Country? r than "natural", or iteme 23a or the Medical Examiner court be 305 ERICSSON ROAD 21610 USA 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11 Marital Status Black, White, etc. within 72 hours after 1 ☐ Yes 2 X No If Yes, Give Year or Dates: 1 Never Married 2 X Married Specify: WHITE Maryland 21215-0036 1 ☐ Yes 2 No Specify: \$ 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) other than College (1-4or 5+) HOMEMAKER OWN HOME of Health and Mental Hygie of Health and Mental Hygie if item 27 is marked other to other treumatic event, in 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Pages 1 and 2 should be VERDA ERWIN SAMUEL BROBST 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) DONALD OWENS/HUSBAND 305 ERICSSON ROAD, BETTERTON, MD 21610 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place 20a. Method of Disposition 20c. Location - City or Town, State Department of H Important: If its eny Injury or ot once. 1 Burial 2 Cremation 3 Removal from State STILL POND CEMETERY 07/06/2006 STILL POND, MD 4 □ Donation 5 □ Other (Specify) permit. 21. Signature of Funeral Service License 22. Name and Address of Facility FELLOWS, HELFENBEIN AND NEWNAM FUNERAL HOME 130 SPEER ROAD, CHESTERTOWN, MD 21620 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Annust **Physician** CARDIOPULLIONARY /Medical Due to (or as a consequence of): Examiner Atual Fibrillation CHRONIC Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner physicien and the burial-transit The law requires that the death certificate be executed HyperTousin that initiated events resulting in death) Last as a consequence of): Box 68760, Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death use 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No ò Day Year 4 Pregnant at time of death 5 Other (specify) ed by the a detached f 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records. TOBACCO ABUSE 1 Yes 2 No 3 Probably 4 Unknown Completed CHRONIC OBSTRUCTIVE PULMINARY Sixese 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No performed' this certificate right lung twice arcinoma 2 No or Attending Physicien: 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification; To 1 ☐ Yes 2 ZNo 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident within 24 hours efter death To the Funeral Director: completely filled in by the 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury · At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Hospital 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical e e 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 123889 (6) completed cause of death 6 m 23a) (Type, Print) , 223 High Street, CHester From, Med 21620 JOHN E. ARKABAL TA, M.D 31. Date filed (Month, Day, Year) 32. Registrar's Signature State

**ORIGINAL** 

Registrar

State of Maryland / Department of Health and Mental Hygiene 2 [] [] [ 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last, Day Month **Physician** ELIZABETH O'DELL JULY 2006 11:00 % /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner QUEEN ANNE'S SCHUYLER HOUSE CHURCH HILL If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months Days 1 ☐ M 2 💢 F Yrs 206-12-0933 04/27/1924 Director Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d. Inside City Limits permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylar Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, the Mudical Examination and page. 1 ☐ Yes 2X No Queen Anne's Directo MD Millington 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21651 USA 105 Squires Ct. Be Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Yes 2X No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married 1 Yes 2 No Baltimore, Maryland 21215-0036 Specify: White 3 Widowed 4 Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Max Paul Miller Margaret Fryer 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) PO Box 436 Millington, MD 21651 Donald O'Dell/Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Chesapeake Cremation 7/8/06 Chester, MD 21. Signature of Funeral Service Licenses 22. Name and Address of Facility Fellows, Helfenbein & Newnam Funeral Home 370 W. Cypress St. Millington MD 21651 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Opset and Death Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Erriei Underfying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Be Completed by Physician/Medical Examiner physicien and s the burial-transit ro the Hospitel or Attending Physician: The law requires that the death certificate be executed Due to (or as a consequence of) Box 68760 IF FEMALE 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.O. 9 Unknown 9 Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I.

Nowtokglins Applicance & CACUA 3 177N 23e. Did tobacco use contribute to the cause of death? Records. 1 Yes 2 No 3 Probably 4 Unknown AF convented to NSR 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No tdvanced 24a. Was an certificate has autopsy perform 1 ☐ Yes 2 No Division of Vital 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 2 2 ER/Outpatient 3 DOA this After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner et Death 28b. Time of Certification; 5 Pending investigation 1 Natural death. 1 ☐ Yes 2 ☐ No 2 Accident Director: 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide within 24 hours after To the Funerel Direc 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) Medical 29a. Certifier (Check only one) and manner stated 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier 021313 (64. Ulum, MD. 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Chestertown (M) 415 Washin 32. Registrar's Signatu 31. Date filed (Month, Day, Year) State 1 0 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 2006 1:00 p **Physician** Jean P. O'Donnell July 9, /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Carroll Westminster #345 225 Frock Drive If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Months Days Hours Min. | Mar 29, 1937 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number **Funeral** Months 1 □ M 2 1 F 69 Washington DC Yrs 578-48-8259 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10b. County 10a. State 28e-f show the Medical Examiner nast be notified at Westminster 1 ☐ Yes 2 XNo Carroll Maryland Director 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number or Items 23a or 21158 225 Frock Drive #345 **USA** 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status permit. Pages 1 and 2 should be filed within 72 hours after to Department of Health and Mental Hygiene. Important: If tiem 27 is marked other than "natural", or Itel any injury or other traumatic svent, it a Micilial Examinations. 1 ☐ Never Married 2 ☑ Married Baltimore, Maryland 21215-0036 white 1 ☐ Yes 2 ☑ No Specify: Specify: þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Give kind of work done during most of working life. DO NOT use retired) (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Clerical Secretary 12 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Katherine Renz John H. Powers 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 225 Frock Drive #345, Westminster, MD 21158 Robert J. O'Donnell, husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 07/10 1 ☐ Burial 2 ☑ Cremation 3 ☐ Removal from State South Carroll Crematory Winfield, MD 2006 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Facility Myers-Durboraw Funeral Home 21. Shinature of Funeral Service Licensee M01191 91 Willis Street, Westminster, MD 21157 23a Papt. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death tmmediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner S—pentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner and Il-transit To the Hospital or Attending Physicien: The law requires that the death certificate be executed Due to (or as a consequence of) attending physician a for use as the burial-Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☐ No 2 Fetal death 3 Ectopic pregnancy Day Month Year 4☐Pregnant at time of death 5 Other (specify) as been signed by the 2 should be detached 9 Unknown 9 Unknowe 23e. Did tobacco use contribute to the cause of death? Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. þ 1 ☐ Yes 2 ☐ No 3 Probably Inknown Completed Were autopsy findings available prior to completion of cause of death?
 □ Yes 2□ No 24a. Was an has page 1□ Yes 2□ 25. Was case referred to medical examiner? 26. Place of Death Check onl director Be Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 ER/Outpatient 3 DOA No. ٩ 1 🗌 Yes 1 Inpatient this After this funeral of 28c. Injury at Work? 28d. Describe how injury occurred 27. Mann Death 28a. Date of Injury (Month, Day Year) 28b. Time of Certification: 5 Pending investigation 1 Natural 1 ☐ Yes 2 ☐ No death. 2 Accident Director: 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number City or Town, State) 4 Homicide within 24 hours a To the Funeral ( Certifying Physician. To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and mainter as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier Medical 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) 29c. License number erson who completed cause of death (Item 23a) (Type, Print) 30 Name and address Westminster MD 21157 555 South Caster Street 32. Registrar's Signature 31. Date filed (Month, Day, Year) State Elsen It sports Registrar 2006

			1 - For State Registrar	State of M		Departmer Certifica			d Mental I	lygier Reg. 1	$-2  \mathrm{n}  \mathrm{n}$	6	23410
	Physic /Medi Exami	cal	1. Decedent's Name (First, Middle, L SENNIFER  4a. Facility Name (If not institution, gi	SERRY ve street and number)				Location of E	2. Date of Month O 7	C	tc. County of		3. Time of Death
	Funeral Director		577-90-7728		ge (In yrs. last birt		r 1 Year	Park If Under 24 Hours	Hrs. 8. Date of (Month, May	Birth Day, Yea	Montgo 967	Birthpla Counti	y ace (State or Foreign ny) ington, DC
	he Maryland 18a-1 show	ector		George's	10c. City, Town	Bladens		ſ				10	d. Inside City Limits 1X Yes 2 □ No
99	within 72 hours after death with the Maryland ene. ene. than "natural", or items 23a or 28a-1 show the Madical Examinar must be mutified at	Funeral Director	10e. Street and Number 4007 53rd Street 11. Marital Status 1 Never Married 2 Married	12. Was Decedent Armed Forces? 1 ☐ Yes 2 💥	Ever in U.S.	13. Was Dece If Yes, spe	dent of Hi		? (Specify Yes or uerto Rican, etc.)		14. Race - Black,	JSA America White, et	n Indian, tc.
Maryland 21215-0036	l within 72 hours iane. r than "natural", the Medical Exe	Completed by	3 Widowed 4 Divorced  15. Decedent's E (Specify only highest given the secondary (0-12)			Decedent's Usu (Give kind of wo life. DO NOT u	al Occupa ork done d se retired,	luring most of )		16b.	Specify: Kind of Busin	ness/Indu	
aryland 2	ges 1 and 2 should be filed within 73 at of Heatth and Mental Hygiene. If Item 27 is marked other than "ni or other traumatic event, the Mauli	To Be C	17. Father's Name (First, Middle, Las  Unknown  19a. Informant's Name/Relationship		19b.			18. Mother's Marc	Name (First, Mide garet r Rural Route Nui	Ada	on Sumame) AMS		No. de l
Baltimore, Ma	permit. Pages 1 and 2 Department of Health a Important: If Item 27 is eny injury or other trau QDCs.		Nestor L. Hernand  20a. Method of Disposition  1 Burial 2 Normation 3 E  4 Donation 5 Other (Special Signature of Funeral Service Lice	Removal from State	20b. Place of cemeters	l007 53r Disposition (Naily, crematory or classification) ale Parl 22. Name ar	d Standards  The of other place  K Cre  Addres	reet 1  ma. 7/ s of Facility	Bladensb Date	20c. Riv	MD 20 Location Cit erdale al Serv	0710 y or Tow , MD vice,	n, State
8760,	Physician /Medical Examiner prize pr	dical Examiner	23a. Part. Enter the disease, or conshock, or heart failure. List only Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, harry leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as b. Due to (or as c.	I the death. Do note.  A consequence of a consequence of	scular n:				arrest,		- 10	Approximate nterval Between Onset and Death
O. Box 6	that the death certifica ed by the attending pt detached for use as t	Physiclan/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☑ Unknown	23c. If yes, outcome 1  Live birth 4  Pregnant at 9  Unknown	2 Fetal death	3 □Ectopic pr 5 □ Other (sp					23d. Date of Month	delivery D	
Records, P.	aw requires is been sign 2 should be	Completed by Pl	Part II. Other significant conditions of	ontributing to death bu	ut not resulting in	the underlying c	ause giver	n in Part I.	24a. Wt	Yes 2	24b. Were	Probab	cause of death?
Division of Vital Records,	ling Physician:  After this certification funeral director,	To Be	25 Was case referred to medical examiner?  1 Yes 2\ No  27. Manner of Death 1\ Natural 5 Pending 2 Accident investigation	Hospital: 1 Anpatiel 28a. Date of Injur (Month, Day			Bc. Injury Work?	. 4 ☐ Nursin		sidence	deati	h? Yes 2[	□ No
DIVIS	Hospital or 4 hours afte Funeral Dir tely filled in I	edical Certification:	3 Suicide 4 Homicide  6 Could not b determined	ysician: To the best of injuner: On the basis of	of my knowledge, examination and/	death occurred	, office	data and ala	City or 1	own, State	9)		Coute Number,
i A	To the within 2 To the complete	M	29b. Signature and title of certifier	Um, M.D		29c	License	number 103		29d. Da	ite signed (M HUST)	onth, Da	
	Sta Registra	te	30. Name and address of person who SAG INSALLI LUNC 31. Date filed (Month, Day, Year)  JUL 1 0 2096	32. Registra			UE	TALL	WHA PA	eu,	MO		

			I - State of Maryland / Dep	partment of Health and Nertificate of Death	lental Hygier Reg.	2000	23411
	Physicia		1. Decedent's Name (First, Middle, Last)  JOYCE D. PRATHER		2. Date of Death JUNE 29	Day 2006	3. Time of Death 9:15AM M
	/Medic Examin		4a. Fecility Name (If not institution, give street and number) 10508 FOXRIDGE CT.	4b. City, Town, or Location of Death MTTCHELLVILL		4c. County of Death	
	Funeral Director		5. Social Security Number  5. Social Security Number  6. Sex 1 M 2X F 62 Yrs.	/) If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birth Month, Day, Ye.	9. Birth WAS	place (State or Foreign D.C.
	ryland thow		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or L				10d. Inside City Limits
	h the Ma or 28e-f s	Director	10e. Street and Number	10f. Zip Code	10g.	Citizen of What Cou	1 X Yes 2 No ntry?
	eath wit		10508 FOXRIDGE CT.  11. Marital Status 12. Was Decedent Ever in U.S. 13.	20721  Was Decedent of Hispanic Origin? (Spr	acify Yes or No-	USA 14. Race - Ameri	can Indian.
036	ours after d	by Funeral	1 Never Married 2 Married I Yes 2 No If Yes, Give Year or Dates:	If Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 【 No Specify:	Rican, etc.)	Black, White,	etc.
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28e-f show amy rightry or other treumetic event. In Medical Francian must be rollined at apprece.	Completed by	(Specify only highest grade completed) (Given	edent's Usual Occupation e kind of work done during most of work DO NOT use retired) ARTIST	ing 16b	Kind of Business/Ir	dustry
and 2	ld be filed vental Hygie kad other ic event.	To Be Co	17. Father's Name (First, Middle, Last) DARIUS PRATHER		First, Middle, Maid	den Sumame)	
Maryland	nd 2 shoul Ith and Mo 27 Is marl treumeti	F	, , , , ,	ling Address (Street and Number or Rura 08 FOXRIDGE CT.		,	
Baltimore,	Pages 1 ar		20a. Method of Disposition 20b. Place of Disp	position (Name of ematory or other of ace) AWN CEM. 7/5,		Location - City or TOCKVILLE	
Balti	permit. Departm Importa any inju		. 1 1 //	22. Name and Address of Facility $W_{ m A}$ $3435~14 ext{th}~{ m ST.,}~{ m II}$			
	Cate be executed / Medical buysician and provided in the private it the private it that it is a second of the private it is a	Examiner	23a. Part1. Enter the disease, or complications that caused the death. Do not enshock, or heart failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  Due to (or as a consequence of):	nter the mode of dying, such as cardiac the su	or respiratory arrest,		Approximate Interval Between Onset and Death
.O. Box 68760,	death certiff e attending id for use as	Physician/Medical		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	ery Day Year
ds, P	es be	by	Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tobaco	co use contribute to t	he cause of death? bably 4 Unknown
Record	The ate h page	Completed			24a. Was an autopsy performed	prior to co death?	opsy findings available impletion of cause of
ion of Vital	nding Physician: Thath. ath. r: After this certificate e funeral director, pag	To Be	25. Was case referred to medical examiner?  1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending investigation  28a. Date of Injury (Month, Day Year)  28b. Time (Month, Day Year)	ent 3 DOA Other: 4 Nursing Ho of 28c. Injury at	n (Check only one) me 5 X Residence 28d. escribe how in		(y)
Division	al or Attending s after death. Il Director: After od in by the fune	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At home, farm, s building, etc. (Specify)	street, factory, office	28f. Location (Street City or Town, St	and Number or Rur ate)	al Route Number,
	To the Hospital or Attending I within 24 hours after death. To the Funeral Director: After Completaly filled in by the funer	edical (	29a. Certifier (Check only one)  Certifying Physician: To the best of my knowledge, deal call Examiner: On the basis of examination and/or in and manner stated.				
)	To the	Σ	29b. Signature and title of certifier	29c. License number	ged. 1	Date signed (Month,	Day, Year)
	310		30. Name and address of person who come ted cause of death (Item 23a) (Type	821 Creen	peth	e# 2	06
	Sta Registr	-	31. Date filed (Month, Day, Year)  32. Registrar's Signature			LAT	en M D WID

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) Day Month Year М **Physician** a 7:11 July 3. 2006 Lillie Mae Padilla /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Prince George's Hospital Center Cheverly if Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Jan. 6, 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) 5. Social Security Number 6. Sex Year) Country)
1940 Washington, , Funeral Min. Months Days Hours 1 □ M 2 1 F 578-52-8052 66 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits the Maryland 10b. County 10a. State show r than "natural", or Items 23a or 28e-f shov the Medical Examiner must be notified at 1 ☐ Yes X ☐ No Silver Spring Maryland Montgomery Direct 10g Citizen of What Country? 10f. Zio Code 10e. Street and Number 20906 IISA 2603 Camel Back Lane, Apt. 7 Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 15 No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerlo Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. within 72 hours after 1 Never Married 2 Married Specify: White Baltimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: δ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15 Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Own Home Homemaker other 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be nd 2 should be fi Ith and Mental H 27 Is marked oth traumatic ever Lillie Salmon Pitt Hockaday Pages 1 and 2 should nent of Health and Men 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20906 19a. Informant's Name/Relationship (Type, Pnnt) 2603 Camel Back Lane, Apt. 7, Silver Spring, MD partment of Health ar portent: If Itam 27 Is y injury or other trace. Melkin N. Padilla/ Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition July 10. 1 XBurial 2 ☐ Cremation 3 ☐ Removal from State Gate of Heaven Cemetery 4 □ Donation 5 □ Other (Specify) 2006 Silver Spring, Maryland Francis J. Collins Funeral Home Inc. 500 University Blvd, W, Silver Spring, Departi Departi Importi any infi 21. Signature of Funeral Service Licenses MD 20901 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Acute Myocardial Infarction /Medical Due to (or as a consequence of): Examiner Ischemic Cardiomyopathy Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner spital or Attending Physician: The law requires that the death certificate be executed tours after death.

nerel Director: After this certificate has been signed by the attending physician and filled in by the funeral director, page 2 should be detached for use as the burial-transit Atherosclerotic Heart Disease resulting in death) Last Due to (or as a consequence of): Box 68760 by Physician/Medical 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Year Day in the past 12 months? 4 Pregnant at time of death 5 Other (specify) ☐Yes 2☐No Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension, Seizure Disorder, Acute Rhabdomyolysis 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? 1 🗆 Yes 2 No 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient 2 ER/Outpatient 3 DOA 1 ☐ Yes 2 ☐ No Certification: To 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 28b. Time of 27. Manner of Death Injury 1 Natural 2 Accident 5 Pending 1 ☐ Yes 2 ☐ No investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 6 Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 3 Suicide 4 Homicide To the Hospital o within 24 hours aft To the Funerel DI (Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29a. Certifier Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. completely 29b. Signature and title of Certifier 29d. Date signed (Month. Dev. Year) 29c. License number 2006 person who completed cause of death (Item 23a) (Type, Print) 30. Name and address of Gorgonia Ferrer 3001 Hospital Drive, Cheverly, Maryland 20785 MD 32 Registrar's Signature 31. Date filed (Month, Day, Year) State 1 1 2006

DHMH 17 Rev 1/2001

Registrar

		1	State of Maryland / Depa	artment of Health and M rtificate of Death		2 11 11 6.	23413
	_		Registrar  1. Decedent's Name (First, Middle, Last)	thoute of Douth	2. Date of Dea	Reg. No U U U	3. Time of Death
	Physicia		Leah Audrey Peregoy		Month 07	Day Year 04 2006	4:55 P M
	/Medic		4a. Facility Name (If not institution, give street and number)	4b. City, Town, or Location of Death	07	4c. County of Death	1.55 1
	Examin	er	Carroll Lutheran Village	Westminster		Carroll	
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24 Hrs.  Months Days Hours Min.	8. Date of Birt (Month, Da	h 0 Rinth	olace (State or Foreign
	Director		215-34-7581 1 M 21XF 87 Yrs.	Months Days Hours Will.	12-17-	1918 Mary	land
	D .		Usual Residence of Decedent           10a. State         10b. County         10c. City, Town or Lo	cation			10d. Inside City Limits
	shov	2					1 ☐ Yes 2 ☐ No
	Ne M	Director	MD Carroll Westmi	10f. Zip Code		10g. Citizen of What Cou	
	with t		299 Luther Drive	21158		USA	ic .
	eath	eral		Was Decedent of Hispanic Origin? (Sp If Yes, specify Cuban, Mexican, Puerto	ecify Yes or No		
36	n 72 hours after death with the Maryland "neturel", or Items 23e or 28a-f show officel Examiner must be rudified at	by Funeral	1 □ Never Married 2 □ Married 1 □ Yes 2127 No	lf Yes, specify Cuban, Mexican, Puerto 1 ☐ Yes 2 No Specify:	Rican, etc.)	Specify:	<sub>etc.</sub> White
21215-0036	2 hou			dent's Usual Occupation kind of work done during most of work	ina	16b. Kind of Business/Ir	ndustry
215	- 75	Completed	Elementary/Secondary (0-12) College (1-4or 5+)	DO NOT use retired)	iiig	Baltimore	County
2	filed wit Hygiene sther the	Son	12 Cafe	teria Manager		Public Sch	∞ls
nd	2 should be filed within 72 hd and Mental Hygiene. Is marked other than "netu aumatic event, II a Medical	Be	17. Father's Name (First, Middle, Last)  Luther A. Martin		e (First, Middle) • Frede:	Maiden Sumame) rick	
yla	should Menind Mening marke	ို		ng Address (Street and Number or Rur			a Codel
Maryland	12 sh and n Ism			Luther Dr., Westm			0 0000)
	ges 1 and 2 should t of Health and Men If item 27 Is marke or other traumatic	-	20b. Place of Disposition	osition (Name of	Date	20c. Location - City or T	own, State
Baltimore,	pernit. Pages Department of I Importent: If it any injury or o		1 \times Burial 2 \( \text{Cremation} \) 3 \( \text{Removal from State} \) \( \text{Y} \) Donation \( 5 \) \( \text{Other} \) (Specify) \( \text{Forest R1} \)	dge Cemetery 07-0		Upperco, Ma	ryland
Balt	permit. Pag Department Importent: any injury c		Roland P. Start MOO550 9	34 South Main St.	, Hamps		74
			23a. Part1. Enter the disease, or complications that caused the death. Do not enishock, or heart failure. List only one cause on each line.	ter the mode of dying, such as cardiac	or respiratory a	rrest,	Approximate Interval Between Onset and Death
響	Priysician	1 1	Immediate Cause (Final disease or condition	eus .			12erly
	/Medical Examiner		resulting in death)  Due to (or as a consequence of):	O			. 1
	LAGITITIES		Sequentially list conditions,  Due to (or as a consequence of):	Dherver has	۰		luk
	ed sit	Examlner	Due to for as a consequence of: cause. Enter Underlying Cause (Disease or injury)	0. 0			v., a
	be executed sician and burial-transit	хап	that initiated events resulting in death) Last c. Due to (or as a consequence of):	senzum			Jun
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687	ficate g phys	edlo	U.				
O. Box	The law requires that the death certificate be executed ate has been signed by the attending physician and bage 2 should be detached for use as the burral-transit	Completed by Physiclan/Me		□Ectopic pregnancy □ Other (specify)		23d. Date of deliv Month	very Day Year
٥	that the by detac	P.	Part II. Other significant conditions contributing to death but not resulting in the u	underlying cause given in Part I.	23e. Did 1	obacco use contribute to	the cause of death?
ds,	uires sign ld be	d b			1 🗆	Yes 2 No 3 Pro	bably 4 □Unknown
Records,	w req beer shou	lete			24a. Was	an 24b. Were aut	opsy findings available
Re	The tav	m d			auto perfo	psy prior to co ormed? death? 2. No 1 □ Yes	ompletion of cause of
Vital		a)	25. Was case referred to medical	26. Place of Dea			
>	8 S E	To B	examiner? 1 ☐ Yes 2 ☑ No Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie	nt 3 DOA Other: 4 Jursing He	ome 5 🗆 Resi	dence 6 Other (Spec	ify)
J of			27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of (Month, Day Year)	of 28c. Injury at Work?	28d. Describe	how injury occurred	
jo	Attending r death. sctor: Afte	atlo	2 Accident investigation	M 1 ☐ Yes 2 ☐ No			
Division	after de Directo	Certification:	3 ☐ Suicide 4 ☐ Homicide  6 ☐ Could not be determined  28e. Place of Injury - At home, farm, st building, etc. (Specify)	treet, factory, office	28f. Location ( City or To	'Street and Number or Ru wn, State)	ral Route Number,
	To the Hospital or Attendir within 24 hours after death. To the Funeral Director: Al completely filled in by the fu	edical C	29a. Certifier (Check only one)  1 Certifying Physicien: To the best of my knowledge, deal (Check only one)  1 Medical Examiner: On the basis of examination and only one)	th occurred at the time, date and place, vestigation, in my opinion, death occur	, and due to the rred at the time,	cause(s) and manner as date and place, and due	stated. to the cause(s)
	ompl	Me	29b. Signature and tiple of certifier	29c. License number		29d. Date signed (Month	Day, Year)
			) / /LA//X	037444		July 5th	2006
	WIL		30. Name and address of person was completed cause of death (tem 28a) (Type	, Print)		0	2457
	10		Bleauder By turchewing	2 horatherne	Such	Zell wester	CMM con
		ate	31. Date filed (Month, Day, Year) 32. Registrar's Signatura	1			
	Regist	rar	JUL 1 0 2006 Jelson &	sperle			

Please Type or Print in Black Indelible Ink Erica C. Pemberton State of Maryland / Department of Health and Mental Hygiene 2006 1- For State Certificate of Death Reg No Registrar Decedent's Name (First, Middle, Last) Physician/ 2. Date of Death Day **Medical Examiner** Erica Chantel Pemberton July 4, 2006 0345 hrs 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death University Hospital-Shock Trauma Baltimore 5. Social Security Number **Funeral** 7. Age (In vrs. last birthday If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY) 9. Birthplace (State or Months Days February 8,199 country Maryland Director 218-27-9196 Hours 1 M 2 X 16 Usual Residence of Decedent 10a State 10c City Town or Location 10d Inside City Limits Charles MD Pomfret 28a-f show 1 Yes 2X No items 23a or 28a-f shoust be notified at once. Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country 4195 Columbia Park Road 20675 USA Funeral 12. Was Decedent Ever in U.S. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 8lack, Armed Forces? 1 X Never Married 2 Married White, etc. Yes 2 X No Yes, Give Year Widowed Divorced Yes 2 X No specify Specify White þ or Dates 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of 8usiness/Industry Completed during most of working life. DO NOT use retired) ages I and 2 should be filed within 72 h
nt of Health and Mental Hygiene
tt: If item 27 is marked other than "n
other traumatic event. the Medical E. Elementary/Secondary (0-12) College (1-4 or 5+) 21215-0036 10 Student High School 17. Father's Name (First, Middle, Last) 18.Mother's Name (First, Middle, Maiden Surname) Eric William Pemberton Sharyn Kae Berry 19a Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Itimore, MD Eric Pemberton/Father Columbia Park Rd. Pomfret, MD 20675 20a Method of Disposition 20b Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State X Burial 2 Cremation 3 crematory or other place) Pages 1 Removal from State partment or Trinity 7/12/06 Memorial Waldorf, Maryland Donation 5 Other Specify Innature of Funeral Service Licenses AREHART ECHOLS FUNERAL HOME, P.A. Echu 23a Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory ck, or heart pproxima e nterval Physician failure. List only one cause on each line Between Onset and /Medical a Head Injuries Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Sequentially list conditions if any, leading to immediate cause. Enter Underlying Cause Due to (or as a consequence of) Examine (Disease or injury that initiated Due to (or as a consequence of) events resulting in death) Last Physician/Medical UNPENDED AMENDED Hospital or Attending Physician: The law requires that the death certificate be Box 68760 phy the b JE FEMALE 23c. If yes, outcome of pregnancy 23d. Date of deliven 23b Was decedent pregnant in the Live birth Fetal death 3 Ectopic pregnancy 2 Day Year past 12 months Pregnant at time of death 5 Other (Specify) 1 Yes 2 V No 9 Unknown Unknown Division of Vital Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e Did tobacco use contribute to the cause of death? 2 1 Yes 2 No 3 Probably 4 Unknown Completed 24a Was an 24b. Were autopsy findings available autopsy prior to completion of cause of has performed? death? page this certificate ✓ Yes 2 No 1 🗸 Yes No 25. Was case referred to medica 26.Place of Death (Check only one) Be examiner? Hospital: 1 🗸 Inpatient 2 ER/Outpatient 3 DOA Nursing Home 5 1 🗸 Yes Residence 6 28a. Date of Injury Jul 3, 2006 \fter Manner of Death 28b. Time of Injury 28c. Injury at Work? 28d Describe how injury occurred Certification Deceased fell from moving vehicle Natural 2154 hrs e Funeral Director: etely filled in by the f Pending Yes 2 V No after death 2 🗸 Accident Investigation 28e. Place of Injury - At home, farm, street, factory, office building, etc. 28f. Location (Street and Number or Rural Route Number, City Could not be Suicide determined (Specify) Local Street 4100 block Columbia Park Road, Pomfret, MD Homicide 29a Certifier Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical within 2 To the 1 Medical Examiner: On the basis of examination and/or investigation in my opinion, death occurred at the time, date and place, and due to the cause(s) and meaner stated 29b. Signati 29c. License numbe 29d. Date signed (Month, Day, Year)

Susan Hogan MD Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Y gistrar's Signati 1 2006 THE .

person who completed cause of death (Item 23a)

State

Registra

O.C.M.E.

July 6, 2006

		-	For State Registrar	ate of Maryland		rtment of H			giene 006	234,15
- 12	· * **	Α	Decedent's Name (First, Middle, Last)					2. Date of Dea	_	3. Time of Death
	Physicia /Medic		Marvin E. Re	amer				- Month	Day 200	
	Examin		4a. Facility Name (If not institution, give stree	t and number)		4b. City, Town, or	Location of Death		4c. County of De	ath
			Doctor's Community H	lospital		Lanham			Prince	George's
t) e	Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las		If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day	, Year) C	rthplace (State or Foreign Country)
	Director	ļ	210-10-93/4	84	Yrs.			March	16, 1922 Ma	ryland
	and w	}	Usual Residence of Decedent  10a. State 10b. County	10c. City,	Town or Loc	ation				10d. Inside City Limits
	Aaryłan f ehow	5	Maryland Prince Geor	ge's Green	nhol+					1 ∑Yes 2 ☐ No
	the t	Director	10e. Street and Number	ge 5 oreer	10010	10f. Zip Code			10g. Citizen of What 0	Country?
	3a or		22 Ridge Road - Apt.	#131		20770		1	U.S.A.	
	death with the Maryland me 23a or 28a-f ehow	Funeral	11 Marital Status 12. V	Vas Decedent Ever in U.S.		as Decedent of Hi	spanic Origin? (S	pecify Yes or No-	14. Race - Arr	
٥	or ite		1 ☐ Never Married 2 X Married 1	rmed Forces?		Yes, specify Cubai		o Rican, etc.)	Black, Wh	ite, etc.
9500-61212	be filed within 72 hours after death with the Maryla tal Hygolen at all Hygolen and tal Hygolen seemed at the Madical Examinar mast by notified at event, the Madical Examinar mast by notified at	by	3 ☐ Widowed 4 ☐ Divorced	l Yès, Give 'ear or Dates:	1	☐ Yes 2M No	Specify:		Specify: W	hite
ည်	72 h	Completed	15. Decedent's Education (Specify only highest grade controls)		(Give I	ent's Usual Occupa	uring most of wor	king	16b. Kind of Busines	s/Industry
2	within 72 ene. then "ne	d d	Elementary/Secondary (0-12)	College (1-4or 5+)	life. D	O NOT use retired,	)		- 4	
Z	lled v tygie ther t		12 17. Father's Name (First, Middle, Last)		Busin	ess Owner		a /First Middle	Recycling Maiden Sumame)	
/land	to pe	Be	Thomas Reamer				Ellen Ry		Maiden Suniame)	
	hould d Me mark matic	2	19a. Informant's Name/Relationship (Type, I	Print	19h Mailin	Address (Street a			r, City or Town, State,	Zio Code)
Mar	ies 1 and 2 should be filed within 7 cf Health and Mental Hygiene. If Item 27 le marked other then *r rother traumatic event, I'ra Mad		Mary L. Reamer - Wif			,			eenbelt, M	
ē,	Hea Hea tem		20a. Method of Disposition	20b. Pla	ce of Dispos	sition (Name of latory or other place	Action - Marie		20c. Location - City of	
ē	Pages nent of int: If it iry or o		1 ☐ Burial 2 🕅 Cremation 3 ☐ Remo	vai troph State	•	,	1	08/2006	Alexandria	, Virginia
saitimore,	pernit. Pages Department of I important: If Ite any injury or of	1	21. Signature of Funeral Service US	-/-	22.	Name and Addres	s of Facility Ga	sch's Fu	uneral Hom	e, P.A.
מ	89 5 8		Howell 11	lay		4739 Balt	imore Av	renue, Hy	yattsville	, MD 20781
	2117		23a. Part 1. Enter the disease, or complication shock, or heart failure. List only one of	use/øn each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	LUTE GEA	EBA	OVASCU	LAR	THEON	180915	Onset and Death 7 DAYS
	/Medical Examiner		resulting in death)	Due to (or as a conseque	ence of):	11. 12	D	100		
		-	Sequentially list conditions, b	Due to (or as a conseque		ULAR	VISE	1186		-
	ted nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a conseque	W100 017.					
	al-tra	xar	that initiated events c resulting in death) Last	Due to (or as a conseque	ence of):					
9/8 8/90	death centificate be executed e attending physician and id for use as the burial-transit	dicai	L d							
9	ificati g phy as the	edic	0							
XOE	eath certific attending p	M/u		f yes, outcome of pregnand		Ectopic pregnancy			23d. Date of d	elivery
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J O	at the de by the stached	Phys	3 □ Ouknown							
	The law requires that the le has been signed by the sage 2 should be detached.	by F	Part II. Other significant conditions contribu	iting to death but not result	ting in the un	derlying cause give	n in Part I.			to the cause of death?
ord	w require been si should b	ted						1 U Y	es 2 No 3 1	Probably 4 MUnknown
Hecords	law las b	ompieted						24a. Was a autop:	sy prior to	autopsy findings available completion of cause of
	(d) (T)	Co						perfor 1 🗆 Yes	med? death? 2 No 1 Ye	
VItal	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	ital:		2CI DOA Othe	ar.	th Check only or		
Ö	Phy this rald	- To	1 163 2 140	mpatient 202	P/Outpatient 28b. Time of	3 DOA	4   Nursing H		ence 6 Other (Sp ow injury occurred	ecity) .
	ding F th. After funera	tion	1 Natural 5 Pending	(Month, Day Year)	Injury	28c. Injury Work	? ′es 2 □No	204. 2000112011	ow injury occurred	
Division	I or Attendi after death. Director: A in by the fu	fica	3 Suicide 6 Could not be	8e. Place of Injury - At horr	ne, farm, stre			28f. Location (S	treet and Number or I	Rural Route Number,
á	al or A s after i Dire	Certification:	4  Homicide	building, etc. (Specify)				City or Tow	n, State)	
	Hospital or Attending     24 hours after death.     Funeral Director: After ietely filled in by the fune		29a. Certifier  (Check only  2 Medical Examiner:	n: To the best of my know On the batis of examination	ledge, death	occurred at the time	e, date and place	, and due to the c	cause(s) and manner a	as stated.
	within 24 h within 24 h To the Fur completely	Medical	29b. Signatury and title of certifier	and manner stated.		29c. License			29d. Date signed (Moi	
	H 3 - 8			1	111			A		
(	DIVH		30. Name and address of person who compl	eted cause of death (Item 2	Sa) (Type I	Print)	1001	0 1	000/ /	
	96		Aliliam > K	2500	7h /	85th	9110 M	ew Car	calltan	, 2006 nd 20784
1	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's Signatu	ITO .	001/1/	100,10	-4/	1011101,	0 20 10 4
1	Registr	ar	JUL 1 1 2006 Like	4 10 100	4					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Day **Physician** David Jonathan ROBINSON 2006 July 9, 2:45 P /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death **Examiner** Rockville Montgomery 5901 Montrose Road #N 208 If Under 1 Year If Under 24 Hrs. Birthplace (State or Foreign Country) 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) **Funeral** Months Days Hours 1**∑**M 2□ F 75 118-26-2275 Yrs. Director Nov. 10, 1930 New York Usual Residence of Decedent with the Maryland 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County Itema 23e or 28a-1 show The Medical Examiner must be notified at 1 ☐ Yes 2 X No Director Rockville Maryland Montgomery 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 20852 United States 5901 Montrose Road #N 208 death Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ▼ Yes 2 No If Yes, Give 1953 Year or Dates: 1953 filed within 72 hours after 1 Never Married 2 Married 6 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: white þ 3 Widowed 4 Divorced "netural", Completed 16b. Kind of Business/Industry 16a. Decedent's Usual Occupation 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) I Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Stockbroker Stocks permit. Pages 1 and 2 should be filed wit Department of Health and Mental Hygiens Important: If item 27 is marked other thus any injury or other traumatic event, Imagence. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Jeannette Neuhoff Maurice Robinson 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20852 5901 Montrose Rd., #N208, Rockville, MD Ruth Robinson, Wife 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State \*4 □Donation 5 □ Other (Specify) Union Field Cemetery | 07/11/06 Ridgewood, NY 21. Signatur of Funeral Sen 22. Name and Address of Facility Torchinsky Hebrew Funeral Home 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. 20012 Approximate Interval Between Onset and Death Immediate Cause (Final Aspiration Pneumonia Priysician disease or condition resulting in death) /Medical Due to (or as a consequence of) **Examiner** Cerebral Vascular Accidents Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the death certificate be executed attending physician and for use as the burial-transit Atrial Fibrillation that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Physician/Medicai Coronary Artery Disease as the IF FEMALE: 23c. If yes, outcome of pregnancy 23d. Date of delivery 23b. Was decedent pregnant 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 3 Ectopic pregnancy Month Day Year in the past 12 months? 5 Other (specify) 1 ☐ Yes 2 ☐ No detached the th 9 Unknown ģ peubis Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by peq 1 Yes 2 No 3 Probably 4 Unknown Decubiti Ulcers, Infected peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an page 2 s autopsy performed? certificate has 1 ☐ Yes 2 ☐ No 1 Yes 2 No or Attanding Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one. Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 No 2 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28d. Describe how injury occurred 27 Manner of Death 28b. Time of Certification: After 1 X Natural Injury 5 Pending 1 ☐ Yes 2 ☐ No within 24 hours efter death.

To the Funeral Director: A completely filled in by the fu investigation 2 Accident 3 Suicide 6 ☐ Could not be 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specily) determined 4 Homicide To the Hospitel 1X Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifief MD 21227 res man 10 2006 25+1 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 20006 Jeffrey Sherman, M.D., 2021 K St., NW, Suite 404, Washington, DC 32 Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 1 1 2006 Registrar

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day Year **Physician** James Robert Rogers July 9 2006 12:19 AM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Union Hospital Cecil Elkton 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1**X** M 2□ F 215-34-1918 69 Director April 20 1937 Maryland Usual Residence of Decedent 10a, State 10c. City, Town or Location 10d. Inside City Limits wou ! e 23a or 28a-f ehov 1 Yes 2 X No Director Maryland Cecil Elkton 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 794 Leeds Road 21921 USA death Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 (XYes 2 □ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status The Mudical Examiner r Black, White, etc. within 72 hours after 1 Never Married 2 Married 5 Maryland 21215-0036 1 ☐ Yes 2 🕱 No Specify: Specify: þ 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry other than Elementary/Secondary (0-12) College (1-4or 5+) 12 Political Consultant Public Service 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Ith and Mental F 27 is marked of traumatic ever permit. Pages 1 and 2 should be Department of Health and Mental Important: If fleen 27 is marked any righty or other traumatic events. James Lee Rogers Martha Connor 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Constance Rogers/Wife PO Box 30 Childs, MD 21916 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 Cremation 3 Removal from State Rosebank Cemetery 4 ☐ Donation 5 ☐ Other (Specify) 7-14-2006 Rising Sun, MD R. T. Foard Funeral Home, P. A. 111 S. Queen Street, Rising Sun, 21. Significant Service Licensee rehard MD 21911 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** MRSA SEPTICEMIN 1 week /Medical Due to (or as a consequence of) Examiner FALLURE ACUTE RENAL Lines if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): physicien end s the burial-transit To the Hospital or Attending Physician: The law requires that the death certificate be executed SEVENE CUP week Due to (or as a consequence of): Box 68760. Physician/Medical EN TERNOCUMENTE CUS FISTULA & AKSCUSS week ettending pl IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 DEctopic pregnancy in the past 12 months? Month Year Day 4 Pregnant at time of death 5 Other (specify) signed by the e O 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, þ 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an certificate has b lirector, page 2 s 2 No 1 ☐ Yes Division of Vital director, Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 ☑ No Hospital: 1 ☑Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 2 After this funeral of 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? Certification: 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 Natural 5 Pending Injury death. 1 Tes 2 No investigation 2 Accident Director: 3 🗌 Suicide 6 ☐ Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide within 24 hours a 1/ Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medicai 29a. Certifier ZU Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D007463 Industry his 7-10-06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Rolando A. Najera, MD 111 W. High St., Suite 214, Elkton, MD 21921 31. Date filed (Month, Day, Year) State Registrar

#### Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Jason Todd Reynolds 1- For State Certificate of Death Registrar Date of Death Decedent's Name (First, Middle,Last) Physician/ Month 0601 hrs July 6, 2006 **Medical Examiner** JASON TODD REYNOLDS 4c. County of Death 4b. City, Town, or Location of Death 4a. Facility Name (if not institution, give street and number) Prince George's Fort Washington Route 210 south of Ft. Washington Road Date of Birth(MM/DD/YYYY 9. Birthplace (State or If Under 1 Year If Under 24Hrs 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) **Funeral** Foreign Country**NFW YORK** Months Davs Hours Min 12/18/1966 Director 088-60-5077 39 1 **X** M 2 Usual Residence of Decedent 10d Inside City Limits Oc. City, Town or Location 10a State 10b. County 1 Yes 2 X No MD CHARLES WHITE PLAINS death with the Maryland Director 10g Citizen of What Country? 10f. Zip Code 10e Street and Number 23a or 28a-notified at c 20695 UNITED STATES 8030 BLOOMSBURY PLACE 13. Was Decedent of Hispanic Origin? (Specify Yes or No-14. Race - American Indian, Black Funeral 12. Was Decedent Ever in U.S. or items 2 must be 1 If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Armed Forces' Never Married 2 X Married 2 X No Yes BLACK Yes 2 X No specify: Give Year Specify Widowed Divorced natural". ģ 16a. Decedent's Usual Occupation (Give kind of work done 16b Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Completed during most of working life DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) h and Mental Hygiene
27 is marked other than "n
matic event, the Medical E 21215-0036 5 ACCOUNTANT ACCOUNTING 18 Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) HERMAN REYNOLDS BESSTE LABAD REYNOLDS SWANN Be traumatic event, 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a Informant's Name/Relationship (Type, Print) ပ 8030 BLOOMSBURY PLACE, WHITE PLAINS, MARYLAND 20695 MARCIA REYNOLDS/WIFE nt: If item 27 i Pages 1 and 2 s nent of Health a 20b. Place of Disposition (Name of cemetery, Date 20c. Location - City or Town, State 20a Method of Disposition Baltimore, crematory or other place) 1 X Burial 2 Cremation 3 Removal from State Important: I injury or oth PLEASANT GROVE CHURCH CEM 07/10/2006 MARBURY, MARYLAND Donation 5 Other Specify Signature of Fune 1,8 ruic Linse )
LYDIA C. THORNION JOHNSON <sup>2</sup> HORNTON FUNERAL HOME, P.A. 3439 LIVINGSION ROAD, INDIAN HEAD, MARYLAND 20640 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart Approximate Interval **Physician** Between Onset and failure. List only one cause on each line. /Medical Death a. Multiple Injuries Immediate Cause (Final disease **Examiner** or condition resulting in death) Due to (or as a consequence of) Sequentially list conditions if any, leading to immediate Due to (or as a consequence of) Examine cause. Enter Underlying Cause Due to (or as a consequence of): events resulting in death) Last and trans Physician/Medical AMENDED attending physician or use as the burial -UNPENDED Box 68760, 23d Date of delivery IF FEMALE: 23c. If ves. outcome of pregnancy 23b. Was decedent pregnant in the past 12 months? Year 3 Ectopic pregnancy Live birth Fetal death Pregnant at time of death 5 Other (Specify, 1 Yes 2 No 9 Unknown Unknown 23e. Did tobacco use contribute to the cause of death? contributing to death but not resulting in the underlying cause given in Part I. Part II. Other significant conditions P. 0. Yes 2 V No 3 Probably 4 þ Completed Records, 24b Were autopsy findings available 24a Was an prior to completion of cause of autopsy death? performed? No ✓ Yes ✓ Yes 2 No 2 26. Place of Death (Check only one) 25. Was case referred to medica Hospital or Attending Physician: Be Division of Vital Other<sub>4</sub> Hospital: 1 Inpatient Nursing Home 5 Residence 6 🗸 Other: Scene ER/Outpatient 3 2 1 🗸 Yes 28d. Describe how injury occurred 28a. Date of Injury Jul 6, 2006 28c. Injury at Work? 28b Time of Injury After 27 Manner of Death Driver auto auto collision Certification: 0543 hrs Natural Yes 2 V No Pending 2 🗸 Accident Investigation 28f. Location (Street and Number or Rural Route Number, City 28e. Place of Injury - At home, farm, street, factory, office building, etc Could not be or Town, State) Route 210 , Fort Washington, MD Suicide (Specify) Highway determined Homicide 29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) within 2 To the ! and manner stated 29c. License number 29d Date signed (Month, Day, Year) 29b. Signature and title of certifie O.C.M.E July 7, 2006 de 30. Name and address of person who completed cause of death (Item 23a) 111 Penn Street, Baltimore, MD 21201 Assistant Medical Examiner Patricia Aronica-Pollak MD. 31. Date filed (Month, Pay, Y State Registrar

		-	For Amend Item 26 per	te of Mar verb.,	yland/Dep G857,022	artment of H 25 (06 dhb rtificate of I	lealth and N Death	ental Hygie	ene No o o c	00110
			Decedent's Name (First, Middle, Last)					2. Date of Death	2000	3. Time of Death
	Physicia /Medic		MARGARET JEAN	RIDGE	LY			JULY 14	, 2006 Year	12:10AM
	Examin		4a. Facility Name (If not institution, give street	and number)		4b. City, Town, or	Location of Death	4c. County of Death		
				VE.		LA PI		CHARLE		
	Funeral		5. Social Security Number 6. Sex		In yrs. last birthday つ Yrs.	Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Ye		place (State or Foreign ntry)
Ь	Director	-	213-32-7680 Usual Residence of Decedent		72 Yrs.			OCT.13	,1933 MA	RYLAND
	/land		10a. State 10b. County	1	Oc. City, Town or L	ocation				10d. Inside City Limits
	the Maryland r 28a-f show	ţċ	MARYLAND CHARLES		L	A PLATA				1√XYes 2 □ No
	ith the	Director	10e. Street and Number		****	10f. Zip Code		10g.	. Citizen of What Cou	ntry?
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		Funerai	An	is Decedent Eve ned Forces?	er in U.S. 13.	Was Decedent of H If Yes, specify Cuba	ispanic Origin? (Sp in, Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - Ameri Black, White	can Indian, , etc.
36	a or	by Fi	1 Never Married 2 Married 1 If 1 3 Widowed 4 Divorced Ye	Yes 2 No 'es, Give ar or Dates:		1□Yes XIXNo	Specify:		Specify: TAT	HITE
5-0036	72 hours after "natural", or ita dical Examina	ba l	15. Decedent's Education	ar or Dates:	16a, Dece	edent's Usual Occup	ation	161	b. Kind of Business/Ir	
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<u>laı</u>		P	F. ADDISON FOWLE	R			GERTRU	JDE SCH	UGARD	
Maryland	sh and sm		19a. Informant's Name/Relationship (Type, Pr	*					ity or Town, State, Zi	
	Health Health tam 27	ij.	HUMPHREY RIDGELY-		D 720 20b. Place of Disp				LATA, MD	
Baltimore,	m 0		20a. Method of Disposition  VSBurial 2 □ Cremation 3 □ Remove		cemetery, cre	ematory or other place		200	c. Location - City or T	own, state
ţ	permit. Page Department Important: Il any injury o	1	• 4 Donation 5 Dother (Specify)	1111		EART CH		-20-06 L	A PLATA,	MARYLAND
Bal	Depa Depa mpo mpo any ir		21. Signature of Funeral Service Licensee	/ M	00479 2	2. Name and Addre		SERVIC	E, P.A.	
		-	23a. Part1. Enter the disease, or complication	that caused th	e death. Do not er	LA PLATA	A , MARYI	AND 206	46	Approximate
	2 50		shock, or heart failure. List only one cau Immediate Cause (Final	se on each line.	-1 no	. 100	011	1 Fa 11	livo	Interval Between Onset and Death
	Physician /Medical	i i	disease or condition resulting in death)	_ Ca	valy	WING	Mary	1 acr	are	
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Вох	eath certifi attending for use as	ian/	in the past 12 months?	es, outcome of Live birth 2	Fetal death 3	□Ectopic pregnancy			23d. Date of deliv Month	ery Day Year
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P.0	res that the igned by be detact	H.	Part II. Other significant conditions contributi	ng to death but r	not resulting in the	underlying cause give	en in Part I.	23e. Did tobac	co use contribute to	the cause of death?
ds,	uires sign ld be	d by	DM-TUDE	7/				1 ☐ Yes	2 No 3 □ Pro	bably 4 □Unknown
00	w require been si should l	Completed	Blowla	1 Di	Sind	2		24a. Was an	24b. Were auto	opsy findings available
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tal		0	25. Was case referred to medical				26 Place of Deat	1 Yes 2	No 1 □ Yes	2L N0
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0	ding Phy After thi funeral			. Date of Injury (Month, Day Y	(ear) 28b. Time	of 28c. Injun Worl		28 Describ how		
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<u> </u>	r Att ter de iract iract	ij	3 Suicide 6 Could not be determined 286	. Place of Injury building, etc. (	- At home, farm, s (Specify)	treet, factory, office		28f. Location (Stree City or Town, S	et and Number or Rur State)	al Route Number,
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	To tha Hospital or Attandi within 24 hours after death. To the Funaral Diractor: A completely filled in by the fu	edical	29a. Certifier (Check only one)  Certifying Physician Medical Examiner: O	n the basis of ex	kamination and/or in					
	To the within 2 To the comple	Mec	29b. Signature and title of certifier	nd manufel state	Q.	29c. Licens	e number	29d.	Date sign#d (Month,	Day, Year)
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	-1,		30. Name and address of person who complete	ad cause of deal	th Item 23a) (Type	Print)	1000	0/	// //	74
	. 8		(20700/MLM	OC-ti	#30	2 4/0	1d0/4	SMO	20600	2
	Sta	te	31. Date filed (Month, Day, Year)	32. Registrar's	Signature		/	/		
	Registr		JUL 2 5 2006	115 D	GORALI					

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 27 2006 Year JUNE Physician 2:15PM ELEANOR С. SHIPP /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner PRINCE GEORGE'S CHEVERLI

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, APRIL 2 PRINCE GEORGES HOSPITAL CHEVERLY 9. Birthplace (State or Foreign 7. Age (In yrs. last birthday) **Funeral** 1 ☐ M 2 🖾 F 77 Yrs. 1929 WASHINGTON, DC 578-36-9197 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10c. City, Town or Location 10a, State 10b. County •how d other then "neturel", or Items 23a or 28a-f ehovevent, the Madical Exemper must be notified at 1¶ Yes 2 □ No RIVERDALE PRINCE GEORGE'S MD Direct 10f. Zip Code 10g. Citizen of What Country? 10e Street and Number U.S.A. 5413 MORTON PLACE 20737 death Funeral 14. Race - American Indian, 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status Black, White, etc. filed within 72 hours after 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married 1 ☐ Yes 2 No Specify: Baltimore, Maryland 21215-0036 Specify: BLACK 2 3 XWidowed 4 ☐ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) COOK PRIVATE 7th 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Pages 1 and 2 should be treent of Health and Mental ANDERSON CALDWELL CLARA EARL. 7 is marked traumatic 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) nt of Health and it is if item 27 is 5413 MORTON PLACE RIVERDALE, MARYLAND 20737 ALONZO BEATTY / SON 20b. Place of Disposition (Name of 20c. Location - City or Town, State 20a. Method of Disposition cemetery, crematory or other place) 1 ABurial 2 ☐ Cremation 3 ☐ Removal from State Department Important: If any injury or once. 7/5/2006 BRENTWOOD, MARYLAND 4 □ Donation 5 □ Other (Specify) Ft.Lincon CEMETERY permit. 21. Signature of Funeral Service Licensee 22. Name and Address of Facility J. B. JENKINS FUNERAL HOME 7474 LANDOVER ROAD LANDOVER, MARYLAND 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician SEPSIS /Medical Due to (or as a consequence of) Examiner STAPHYLOCOCCUS BACTEREMIA Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine The law requires that the death certificate be executed ACUTE RESPIRATORY FAILURE physician ar Due to (or as a consequence of): Box 68760 ician/Medical ALZHEIMER DEMENTIA IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy Month Day Year in the past 12 months? 1 ☐ Yes 2 ☐ No 4☐Pregnant at time of death 5 Other (specify) P.0. detached Physi 9 Unknown 9 Unknown 23e. Did tobacco use contribute fo the cause of death? Part II. Other significant conditions contributing to death but not resulfing in the underlying cause given in Part I. ģ Division of Vital Records, ate has been sign page 2 should be 1 ☐ Yes 2 No 3 ☐ Probably 4 ☐ Unknown Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 2 ☒ No or Attending Physician: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🗓 No 1 Nation 2 ER/Outpatient 3 DOA Certification: To s after dea.
real Director: After ...
hy the funeral di 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 27. Manner of Death 1 XNatural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, sfreet, factory, office building, etc. (Specify) filled in by 4 Homicide To the Hospital within 24 hours a To the Funeral C 1 Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29c. License number 29d. Date signed (Month, Day, Year) of certifier 29b. Signature an 00055100 29/06 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) CHARLES AGBEMABIESE M.D. 3001 HOSPITAL DRIVE CHEVERLY, MARYLAND 20785 32. Registrar's Signature 31. Date filed (Month, Day, Year) State JUL 0 7 2006 Registrar

			1 - For Stete Registrar	State of M	larylar				lealth a Death	ind Me		giene	106	23422
ı	Physicia		Decedent's Name (First, Middle, Las.	Lewis SI	HABAS	SON					2. Date of Dea Month July 6	th Day	Year	3. Time of Death 5:25 P M
	/Medic Examin		4a. Facility Name (If not institution, give		treet and number)  4b. City, Town, or Location of Death					oury c	4c. Coun	ty of Death		
	Funeral Director		Casey House Montg           5. Social Security Number         6. Security Number           140-30-3934         140-30-3934			last birthday) Yrs.		ockv1 or 1 Year Days	IIe If Under 2 Hours	Min.	8. Date of Birth (Month, Day Mar. 10	Year)	Cou	place (State or Foreign intry) and
	Maryland f ehow	tor	Usual Residence of Decedent           10a. State         10b. County           Maryland         Montgome	rv	10c. Ci	ty, Town or Lo								10d. Inside City Limits 1 ☐ Yes 2 1 No
	h with the	ai Direc	10e. Street and Number 6111 Montrose Road				10f. Z	p Code	20852			10g. Citizen of United		•
036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Depertment of Heelih and Mental Hygiene. Depertment of Heelih and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show important: If item 27 is marked other than "natural", or items 23a or 28a-f show eny liquity or other treumatic event, the Medical Examinar must be notified at once.	Completed by Funeral Director	11. Marital Status  1 Never Married 2 Married  3 Morital 4 Divorced	12. Was Decedent Armed Forces 1 Tyes 20 If Yes, Give Year or Dates:	?	1	Was Dece f Yes, sp	ecify Cuba	ispanic Orig n, Mexican, Specify:	gin? (Spec , Puerto F	cify Yes or No- lican, etc.)	Bla	ice - Ameriack, White	
Maryland 21215-0036	Jwithin 72 ho piene. r than "natur the Wedical	ompieted	15. Decedent's Edi (Specify only highest grad Elementary/Secondary (0-12) 12	le completed) (Give ki			kind of w DO NOT	ork done d ise retired	turing most	of workin	g	16b. Kind of Business/Industry  Private Investor		
yland ;	buld be filed Mental Hyg arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last)  Ezra Zelig						Faig	a Le	(First, Middle, ah Grum	Maiden Suma l <b>an</b>	тө)	
Mar	nd 2 sh alth and 27 ie m r treum		19a. Informant's Name/Relationship (T. Zella Shabasson, I				-				Route Numbe Silver			20904
Baltimore,	Pages 1 and Henderl of Heem Int. If item		20a. Method of Disposition 1 Spurial 2 Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify,		,   '	Place of Dispo cometery, cren	natory or	other plac		7/0 <sup>8</sup>		01ney,		own, State
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	Physician		23a. Part 1. Enter the disease, or comp shock, or heart failure. List only of Immediate Cause (Final disease or condition	lications that cause one cause on each l	iine.				g, such as o	cardiac or	respiratory arr	est,		Approximate Interval Between Onset and Death
	/Medical Examiner	_	resulting in death)  Sequentially list conditions,	Due to (or as	tive	Heart :	Fail	ire						
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P.O. Box 68	law requires that the death certifica as been signed by the attending ph 2 should be detached for use as th	by Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown					□Ectopic pregnancy □Other (specify)					ate of deliv	ery Day Year
	w requires that been signed b should be deta	ed by PI	Part II. Other significant conditions co	ntributing to death I	but not res	sulting in the ur	nderlying	cause give	en in Part I.			bacco use cor es 2□No	atribute to t	he cause of death?
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Vita	Physicien: Tripis certifice	Be	25. Was case referred to medical examiner?	Hospital:		1500		Othe			Check only or	700		TT
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Division	5 5 5 c	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)						2	8f. Location (S City or Town	treet and Num n, State)	ber or Rur	al Route Number,
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	To the vithing To the comp	M	29b. Signature and tyle of certifier		~	<b>V</b>	29	c. License D	35635	j	Z	9d. Date sign July		· .
	9		30. Name and address of person who co Joseph Kaplan, M.I			n 23a) (Type, ster M		Rđ.,	Rockv	ille	, MD 2	0855		
	Sta Registr		31. Date filed (Month, Day, Year)	32 Regist										

State of Maryland / Department of Health and Mental Hygiene 🤈 Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death Day Month **Physician** Ам SHARPS July 2006 0943 JOSEPH . S. /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Prince George's Southern Maryland Hospital Clinton If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 213-34-6570 71 Director February 28, 1935 Maryland Usual Residence of Decedent 10c. City, Town or Location 10a. State 10b. County 10d. Inside City Limits 28a-f ehow other treumatic event, the Medical Examiner must be notified at 1 Yes 2 □ No Directo Maryland Prince George's Capital Heights 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? or iteme 23a or 20743 U.S.A. 4901 Cunter Street 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11. Marital Status within 72 hours after 1 Yes 2 No If Yes, Give X Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ₹ No þ Specify: Black 3 ☐ Widowed 4 X Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry d 2 should be filed within the and Mental Hygiene.
7 ie marked other then " Elementary/Secondary (0-12) College (1-4or 5+) Truck Driver Self 8th Grade 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Marion Butler Joseph H. Sharps 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 st Department of Health and Important: If Item 27 ie n eny Injury or other treun 4901 Gunter Street Capital Heights, Maryland John Sharps 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition t Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) July 12, 2006 Anne-Arundel County Moses Cemetery 22. Name and Address of Facility Rollins Funeral Home, Inc. 21. Sign (ture of Funeral Service Licensee 4339 Hunt Place, N.E. Washington, D.C. Approximate Interval Between Onset and Death Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or heert failure. List only one cause on each line. Immediate Cause (Final disease or condition Physician ACUTE MYOCARDIAL INFARCTION resulting in death) /Medical Due to (or as a consequence of): Examiner ARTERU CORONARY Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of) Examiner the ettending physician and ched for use as the burial-transit death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death
4 ☐ Pregnant at time of death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Day 5 Other (specify) 1 Yes 2 No should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown HYPERTENSION peen CEREBRO VASCULAR DISEASE 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed 2 2 No 1 Yes 2 No t 🗌 Yes Division of Vital the Hospital or Attending Physician: director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) examiner? 1 → res 2 □ No Hospital: 1 ☐ Inpatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) 2 2 ER/Outpatient 3 DOA neral Director: After the filled in by the funeral 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Certification: 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after d To the Funeral Direct completely filled in by 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a Certifier 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified D40324 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 4 7503 SUKRAITS ROAD, CLINTON MAKYLAND JOARIE, MID. TERRY 32. Registrar's Signature 31. Date filed (Month, Day, Year) State 2 2006 Registrar

# Please Type or Print In Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene

			C	ertificate of	Death		Reg. No.	Ub	23424	
DI	1. Decedent's Name (First, Middle, La	st)				2. Date of Do	∋eth Dav	Year	3. Time of Death	
Physician /Medical	Katherine	Smi	th			July 5	, 2006		11:45 AM	
Examiner	4a Facility Neme (If not institution, giv	e street and number)			4b. City, Town, or	Location of Dea	th 4c. County	of Deeth		
	Manor Care Chevy	Chase			Chevy C	Chase	Mont	gomery	,	
Funeral	5. Social Security Number 6. S		rs. last birthda	y) If Under 1 Year Months Days			rth ay, Year)	9. Birthplac	ce (State or Foreign	
Director	198-03-9165	□ M 20XF	96 Yrs.				26,1910	PA	,	
P >	Usual Residence of Decedent  10a. State 10b. County	100	City, Town or	Lacation				104	I. Inside City Limits	
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er de Memi	11. Marital Status	12. Was Decedent Ever in Armed Forces?	n U,S. 13	B. Was Decedent of If Yes, specify Cub	Hispanic Origin? ( pan, Mexican, Pue	specify Yes or Norto Rican, etc.)	Blac	ce · American ck, White, etc		
urs a urs a by	1 ☐ Never Married 2 ☐ Married 3 🛱 Widowed 4 ☐ Divorced	1 Tyes 2 X No If Yes, Give Year or Dates:		1 ☐ Yes 2 🗓 No	Specify:		Specify	y: Whit	e	
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Be (	17. Father's Name (First, Middle, Last)				18. Mother's Na	ame (First, Middle	, Maiden Surnarr	10)		
should be nd Menta nmarked umatic ev	Herbert Miller				Cath	erine l	Baines			
s mand l	19a. Informant's Name/Relationship (	Type, Print)	19b. Ma	iling Address (Stree	t and Number or F	Rural Route Numb	er, City or Town,	State, Zip Co	ode)	
and 2 and 2 s 27 i	Carl H. Smith/ S	on	61	Main Stre	et Bowdo	inham, N	Maine 04	800		
of Harritan	20a. Method of Disposition	20	<ul> <li>Place of Dis cemetery, ca</li> </ul>	position (Name of rematory or other pla	ice)	Date	20c. Location ·	City or Town	ı, State	
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Physic of this of all dire	1 ☐ Yes 2 ZNo 27. Menner of Deeth	1 ☐ Inpatient 2	ER/Outpati 28b. Time	ent 3LI DOA	4 Mursing		idence 6 Oth how injury occur			
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LIVISION OF VITAL DECORDS, tal or Attending Physician: The law requires the after death.  In prector, After this certificate hes been signed in by the funeral director, page 2 should be certification: To Be Completed by	4 Homicide determined	building, etc. (Spe		street, ractory, office		City or To	wn, State)	or or ribrarri	oute Number,	
Hospital Roburs Puneral Rely filled	29a. Certifier 1 X Certifying Ph	ysician: To the best of my l	cnowledge de	eth occurred at the ti	me date and plac	e and due to the	cause(s) and ma	anner as state	ed	
To the Hospital or Attending Physician: The Inwithin 24 hours after death, within 24 hours after death, completely filled in by the funeral director, page Medical Certification: To Be Com		niner: On the basis of exam and manner stated.								
within to the comple	29b. Signature and title of certifier	.2		29c. Licen	se number		29d. Date signe	d (Month, Da	y, Year)	
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DHMH 16 Rev 6/95

State of Maryland / Department of Health and Mental Hygiene) Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 8:55 P M **Physician** ALICE THOMAS July 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) Center 4h. City. Town, or Location of Death Examiner Forestville Health & Rehabilitation Prince George's District Heights If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 □ M 2 XF 82 579-62-5207 Sept. 18, 1923 Maryland Director Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10a, State 10b. County rthan "neturel", or Items 23a or 28e-f show the Medical Examinations be notified at 1 Ves 2 □ No District Heights Prince George's Maryland Direct 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 20747 USA 7420 Marlboro Pike death v Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ≥ M No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian Black, White, etc. filed within 72 hours after 1 Never Married 2 Married Itimore, Maryland 21215-0036 1 ☐ Yes 2X No Specify: Specify: Black δ 3 ₩ Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. OO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) College (1-4or 5+) Elementary/Secondary (0-12) Care Giver Private . Pages 1 and 2 should be filed vitment of Health and Mental Hygie tant: If item 27 is marked other fully or other traumatic event, it. 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Williams Franklin Beatrice Charlie ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Josephine Marie Blake (Cousin) 4801 Fable Street Capitol Heights, MD 20743 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State
4 ☐ Donation 5 ☐ Other (Specify) permit. Page Department of Important: If any injury or once. Riverdale Park Crema. 7/9/06 Riverdale, MD 21. Sign fure of Funeral Service Cloensee 22. Name and Address of Facility Jordan Funeral Service, 4001 Benning Road, NE Washington, DC 23a. Part 1 Ther the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Arteriosclerotic Heart Disease Physician disease or condition resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): Examiner The law requires that the death certificate be executed attending physician and I tor use as the burial-transit resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4□Pregnant at time of death 5 ☐ Other (specify) 1 ☐ Yes 2 XNo been signed by the should be detached 9 Unknown Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? à Seizure Disorder Cerebral Infarction 1 Yes 2 No 3 Probably 4 Nunknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No Peripheral Vascular Disease 24a. Was an certificate has birector, page 2 s rmea? 2X No 1 Yes To the Hospitel or Attending Physicien: within 24 hours after death.

To the Funerel Director: After this certifica completely filled in by the funerat director, p 26. Place of Death (Check only one) Be 25. Was case referred to medical Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 XNo ပို 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 TYes 2 No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 | Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medicel Exeminer: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier (Check only one) 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certified 2006 D0026024 6 blu July 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 6490 Landover Road, Suite F Landover, MD Lester M. Miles, MD 31. Date filed (Month, Day, Year) State Registrar

State of Maryland / Department of Health and Mental Hygiene For Stata Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** 9:45 p Ju1v 6, 2006 VIRGIL ELZIE THOMAS /Medical 4c. County of Death 4b. City. Town, or Location of Death 4a. Facility Name (If not institution, give street and number) Examiner Manor Care Silver Spring Nursing Home Montgomery Silver Spring If Under 1 Year | If Under 24 Hrs. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** Months Days Hours Min 1ĬM 2□F 83 224-34-9185 16, Virgínia Dec. Director Usual Residence of Decedent with the Manyland 10c. City, Town or Location 10d, fnside City Limits 10a. State 10b. County r then "natural", or Items 23a or 28a-f ehow the Medical Examinar must be notified at 1 XYes 2 No Directo Maryland Prince George's Greenbelt 10g. Citizen of What Country? 10e. Street and Number 10f. Zin Code 5833 Cherrywood Terrace, Apt. 104 20770 U.S.A. Funerai filed within 72 hours after deeth 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. 11. Marital Status 1 ∑Yes 2 ☐ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 X Married Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: White ģ 3 ☐ Widowed 4 ☐ Divorced WWII Completed 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Bookkeeper permit. Pages 1 end 2 should be filed v Department of Heelih and Mental Hygies Important: If Item 27 is marked other the eny Injury or other traumatic event, the once. Private Industry 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Fannie Turner Richard Elzie Thomas 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20770 19a. Informant's Name/Relationship (Type, Print) 5833 Cherrywood Terrace, Apt. 104, Greenbelt, MD Maryalice N. Thomas - Wife Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 Cremation 3 ☐ Removal from State 7/11/2006 4 ☐ Donation 5 ☐ Other (Specify) Metropolitan Crematory Alexandria, Virtinia 21. Signature of Euroral Service Licensee 22. Name and Address of Facility Gasch's Funeral Home, P.A. 4739 Baltimore Ave., Hyattsville, MD 20781 Min 611111112 Approximate Interval Between Onset and Death 23/Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each fine. Immediate Cause (Final disease or condition resulting in death) Physician Sepsis 3 weeks /Medical Due to (or as a consequence of): Examiner Urinary Tract Infection 3 weeks Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to for as a sonsequence of Examiner signed by the attending physiclen and be deteched for use as the burial-transit Hospital or Attending Physicien: The law requires that the death certificate be executed Chronic Obstructive Lung Disease Years Due to (or as a consequence of): Box 68760, Completed by Physician/Medical IF FEMALE: 23c. ff yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day 4 Pregnant at time of death 5 Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 1 ☐ Yes 2 ☐ No 3 Ĭ Probably 4 ☐ Unknown Failure to Thrive; Dementia 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an page 2 s autopsy performed? 1 Yes 2 🔀 No To the Hospital or Attending Physicien: within 24 hours effer death.

To the Funerel Director; After this certific completely filled in by the funeral director, Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 🗌 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28d. Describe how injury occurred 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No м investigation 2 Accident 3 🗌 Suicide 6 Could not be Location (Street and Number or Rural Route Number, City or Town, State) 28e. Pface of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) xuman July 10, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 3503 Perry Street, #B, Mount Rainier, Maryland 20712-2141 Raman R. Tuli, MD 32. Registrar's Signature

State Registrar 31. Date filed (Month, Day, Year)

1 1 2006

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Honore Tiffey Clune рм July 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 11925 Goya Drive Potomac Montgomery If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) **Funeral** 1 M 2 F 060-32-3122 Director 66 July 19, 1939 New York Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location in then "neturel", or items 23s or 28s-f ehow the Medical Examinar most be notified at 10d. Inside City Limits 1 ☐ Yes 2 ▼ No Directo Maryland Montgomery Potomac 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 11925 Goya Drive 20854 USA death 1 by Funerai 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours efter 1 Yes 2 XNo
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 TNo Specify: SpecifyWhite 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Homemaker Own Home other 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be and Mental h John Patrick Clune ပ္ Eleanor Lynch 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Edward Lee Tiffey/ Husband itsm 27 i 11925 Goya Drive, Potomac, Maryland 20854 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State Dependent of Himportant: If its Indus or 1 Durial 2 ☐ Cremation 3 ☐ Removal from State July 14, 2006 Gate of Heaven Cemetery 4 ☐ Donation 5 ☐ Other (Specify) Silver Spring, Maryland 21. Signature of Funeral Service Licensee Francis Adress Cornins Funeral Home Inc. any ir coler ames 500 University Blvd, W, Silver Spring, MD 20901 23a: Part1. Inner the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Metastatic Renal Cell Cancer 4 Months /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, loading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of): The law requires that the death certificate be executed physicien and s the burial-transit Exam resulting in death) Last Due to (or as a consequence of) Box 68760. Physician/Medical attending pl IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 ☐ Fetal death 23b. Was decedent pregnant in the past 12 months?
1 ☐ Yes 2 ☒No 23d. Date of delivery 3 Ectopic pregnancy Month Day Year 4 Pregnant at time of death 5 Other (specify) P.O. I been signed by the should be detached 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Records, <u>م</u> Completed 1 Yes 2 No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? s certificete hes t lirector, page 2 s autopsy 2 ⊠ No Division of Vital 1 Yes 2 No 1 Yes Hospital or Attending Physician: director, Be 25. Was case referred to medical 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 1 ☐ Yes 2 No Medical Certification: To this within 24 hours efter death.

To the Funerel Director: After the completely filled in by the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Matural 2 Accident 5 Pending investigation 1 Yes 2 No 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide Physician: To the best of my knowledge, death oncurred at the time, date and clade, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a Certifier (Check only one) To the ! 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D33293 12 July 10, 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Frederick P. Smith, M.D. 5454 Wisconsin Avenue, #1300, Chevy Chase, MD 20815 31. Date filed (Month, Day, Year)

11 2006 32. Registrar's Signature State Registrar

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			Decedent's Name (First, Middle, Last)		2. Date of Deat	h	3. Time of Death
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1	Examin	ier	Washington Adventist Hospital				
1418	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthda)		8. Date of Birth	Montgo 9. Birt	
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Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

2006 23429

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The state of the s		4a. Facility Name (if not institution Prince George County)		umber)		45	c. City, Town, or Lo Cheverly	ocation of	Death		4c. County		
Funeral	-	Social Security Number	hday)	If Under 1 Year	If Under	24Hrs.	8. Date of Bir	rth(MM/DD/YYY	Y) 9. Bir	thplace (State or			
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Baltimore, MD 21215-0036 permit. Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If item 27 is marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once		Nina B. Thomas (Wi	fe)	Too									
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		or condition resulting in death)	Due to (or as a	consequence	of):								
	<u></u>	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a	consequence	of):								
d Sit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a	a consequence	of):					_		- '	
68760, certificate be executed nding physician and use as the burial - transit	n/Medical E	X UNPENDED	d	00 07	107	061 1:	1/1//06 500			····			
8760, tificate be ng physicias the buria	leg	IF FEMALE:	23c. If yes.	23a,2/,pe	envil,	g861,1	1/14/06 TT				23d. Date o	f delivery	
687 certific	jan/	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy  4 Pregnant at time of death 5 Other (Specific)											
Vital Records, P.O. Box 68' hysician: The law requires that the death certificate has been signed by the attending I director, page 2 should be detached for use as I	Physicia	1 Yes 2 No 9 Unk	nown 9 Unkn		death 5	Othe	er (Specify)				4		9
P.O. Box		Part II. Other significant conditi	ons contributing to	o death but not	t resulting	g in the und	derlying cause give	en in Part	i I.	23e. Did to	obacco use cont	ribute to	the cause of death?
S, P.O.	d by									1 Yes	2 <b>V</b> No 3	Prob	ably 4 Unknown
ord: w requas been	Completed	<u> </u>								24a Was autop	sy	prior to c	topsy findings available ompletion of cause of
Rec The la	E									perfo 1 <b>Y</b> Yes		death? ✓ Ye	s 2 No
ian:	Be C	25. Was case referred to medical examiner?					26.Place of		Check on	ly one)			
Vit hysic rthis	힏	1 🗸 Yes 2 No		Inpatient 2		·					Residence 6	Other	
Division of Vital Records, ral or Attending Physician: The law requir is after death.  al Director: After this certificate has been is led in by the funeral director, page 2 should		27. Manner of Death  1 X Natural 5 Pend		of Injury n, Day,Year)	28b.	Time of Inju		at Work? s 2 1		8d. Describe	how injury occur	redi	
ivisior I or Attend after death Director:	<u>icat</u>	2 Accident Inves	stigation 28e Plac	e of Injury - At	home fa	ırm street	factory, office buil			8f Location /	Street and Numb	er or Ru	ral Route Number, City
Divis spital or At ours after d teral Direct filled in by	Certification:		d not be mined (Specify)			,	,,	renngj ene	-	or Town, S		or or real	ar reade reambor, only
~ = -		29a. Certifier 1 Certifying Pl	nysician: To the bes										
To the within	Medical	one) 2 Medical Example 29b. Signature and title of certifie	and manner s		and/or n	ivestigatio	29c. License r		arred at ti	ne time, date	29d Date sign		
	_	Mich	\/U				O.C.M.				1/1/1	1 11	7 2001
	-	30. Name and address of person	who completed cau	se of death (Ite	m 23a)		1				JUIL	-	11 6000
₹ _			Assistant Medic				Street, Baltim	nore, M	D 2120	01			
Sta Regist		31. Date filed (Month, Day, Year)	2006	egistrar's Signa	ature	freel							

			1 - For State Registrar	State of Mary		artment rtificate			nd Ment	al Hygie	21111	6 23430
	Dhusia		1. Decedent's Name (First, Middle, L	ast)						ate of Death	Day	3. Time of Death
	Physic /Medi		Lemuel Rudol	ph Thomas	Sr					onth alv 1.	Day Year	12:30P M
	Exami		4a. Facility Name (If not institution, g	ive street and number)		4b. City, 7	Town, or Lo	ocation of			4c. County of De	
			7824 Glastenbu	ary Court		Wh	ite	Plai	ins		Charle	2 g
	Funeral		,	Sex 7. Age (In 1.2X M 2□F	yrs. last birthday)	If Under Months		If Under 2 Hours	4 Hrs. 8. Da Min. (M	ite of Birth lonth, Day, Ye	ar) 9. B	irthplace (State or Foreign Country)
	Director		579-10-9381	TUSIN ZUF	88 <sup>Yrs.</sup>					1.17,1		ash.,DC
	and *		Usual Residence of Decedent  10a. State 10b. County	100	. City, Town or Lo	ocation						
	Aaryl sho	5	MD Charle									10d. Inside City Limits 1 X Yes 2 No
	28a-	Director	MD Charle  10e, Street and Number	es w	hite P					1		
	with	ā		www. Count		10f. Zip		_			Citizen of What (	•
	eath	Funeral	7824 Glastenbu	12. Was Decedent Ever	in II S 12		2069		i=2 /C===#+. V		ited St	
10	Iter d	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 🕱 No	110.3.	If Yes, speci	fy Cuban, I	Mexican,	in? (Specify Yo Puerto Rican,	etc.)	14. Race - Arr Black, Wh	
936	urs a	by	3 ∰Widowed 4 □ Divorced	If Yes, Give Year or Dates:		1 ☐ Yes 2	No S	Specify:			Specify: D	lack
5-0036	72 hours after death with the Maryland "natural", or Iteme 23a or 28a-f show idical Examiner must be notified at	Completed	15. Decedent's I	Education		dent's Usual				16b	. Kind of Busines	
21	- 3	pje	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5+)	(Give	kind of work DO NOT use	k done duri. e retired)	ing most o	of working			,
2121	giene.	P	9		Gas S	Suppl	у Те	chni	ician	W	GL Com	panv
	be filed withir stal Hygiene. Ind other than event, the M	Be	17. Father's Name (First, Middle, Las	t)					's Name (First,			
/a	should be nd Menta i marked imatic ev	2	Lemuel Thomas					Rosi	ie Sim	lev		
Maryland	2 should and Mer is marks		19a. Informant's Name/Relationship	(Type, Print)	19b. Mailin	ng Address (	(Street and	<i>Number</i>	or Rural Route	e Number, Cit	y or Town, State,	Zip Code)
	ロミトラ		Wayne Thomas/s	son	WEIT	e FI	sten. ains	bury	Cour 206	\$5		
Baltimore	ges 1 and t of Heeli if item 2 or other		20a. Method of Disposition 1 XBurial 2 ☐ Cremation 3		b. Place of Dispo	isition (Nami	e of	, ,	Date	20c.	Location - City o	r Town, State
Ĕ	it. Pag rtment rtant: I njury o		4 Donation 5 Other (Spec		ashingt	•		em.	7/11/	06 S	uitland	- MD
at			21. Signature of Funeral Service Lice			2. Name and					Edwards	
0	Ped of the same		Januce &	dwardo	ノ 3	3910	Silve	er H				d,MD.20746
			23a. Party. Enter the disease, or cor shock, or heart failure. List only	nplications that caused the o	leath. Do not ent	er the mode	of dying, s	such as ca	ardiac or respi	ratory arrest,		Approximate
	Physician		Immediate Cause (Final disease or condition	Sile of	11111	0,00	111	14	Trope.	Hm	14	Interval Between Onset and Death
	/Medical		resulting in death)	Due to (or as a con	sequence of):	0	i	-//	11	11-	2	2-3 mms
н	Examiner		Conventially list and divisor	1 Under	- bunc	mere	2/12	Ve la	tears	+ Face	uce	2 Hears
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a con	sequence of):				0	/ -	4	
	nd rans	Examin	that initiated events	c. Undt	rlyla	s Co	rond	ary	ast	ery	115-	
Ö,	be executed sician and burial-transit		resulting in death) Last	Due to (or as a con			P.	. /	/	0	11	2./
37	age of d	Physician/Medical	•	d	Cur	5 mg	Cu	em	s my	opas	My	20/30 yps
9	death certific e attending pl od for use as t	Med	IF FEMALE:	·								,
Вох	ath ce ttend or us	an/	23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome of pre 1 ☐ Live birth 2 ☐ F		Ectopic pred	gnancy				23d. Date of de	
<u>.</u>	0 0 0	sic	1 Yes 2 No	4□Pregnant at time of the second of the sec		Other (spec					Month	Day Year
P.O.	that the de ned by the a detached f	F.			77.							
	The law requires that the the has been signed by th bage 2 should be detache	by	Part II. Other significant conditions	contributing to death but not	resulting in the ur	nderlying cau	use given in	n Part I.	23			o the cause of death?
oro	neen s	ted	- Mevall2	ed de DIII	Tation	due	40			1 ☐ Yes	2 No 3 □ P	robabły 4 Dunknown
ec	law lasb	pie	advanc	ed arge					24	a. Was an autopsy	24b. Were a	utopsy findings available completion of cause of
	The Sete P	Completed							1	performed?	death?	
/ita	Physician: Th r this certificete ral director, pag	Be	25. Was case referred to medical examiner?				26	S. Place of	f Death (Chec			
£	shyei this c	۵,	1 ☐ Yes 2 🛣 No		ER/Outpatien	t 3□ DOA	Other:	4 🗌 Nursi	ing Home 5	Residence	6 ☐Other (Spe	ecify)
ū	ding P h. After i funera	ö	27. Manner of Death 1 2Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Year	28b. Time of Injury	280	c. Injury at Work?		28d. De	scribe how in	ury occurred	
sio	Attending r death. ector: After by the fune	cati	2 ☐ Accident investigation			М	1 🗆 Yes	2 🗆 No	)			
≥	l or Attene efter deatl Director: I in by the	Certification;	3 ☐ Suicide 6 ☐ Could not to determined		it home, farm, stre ecify)	eet, factory,	office		28f. Loc City	ation (Street a	and Number or R	ural Route Number,
	urs e											1
	To the Hospital or Atlanding Physician: The within 24 hours eiter death. To the Funerel Director: Atler this certificete he completely filled in by the funeral director, page	edical	Check only 2 Medical Exa	hysician: To the best of my l	knowledge, death ination and/or inv	occurred at restigation, in	the time, d	date and p	place, and due	to the cause	s) and manner as	s stated.
	the the mple	Med		and manner stated.								
	¥ ¥ 6 8	-	29b. Signature and title of certifier	1 Time	7		License nui		37	29d. D	ate signed (Mont	th, Day, Year)
			/ Sectord of	tames !!	0	3	00				1/06	
	12		30. Name and address of person who	10 - 1-	tem 23a) (Type, I	Print)	.,	7			1/1	MD 20603
			31. Date filed (Month, Day, Year)	VSON, MD	10 57 a	rain	ul	Vr	>te 2	03 U	wedowt,	101 20603
T:	Sta Registr		11. Date filed (Month, Day, Year)	32. Registrar's Sig	and the second						·	
	3 3 3 3 1 3 1		JUL - ~ 2000									

			1 - For State Registrar	State of Maryla	and / Depa <i>Cei</i>	artment of I rtificate of	Health and Death		iene2006	23431
	2,		1. Decedent's Name (First, Middle, La	st)	-			2. Date of Deat	th	3. Time of Death
	Physici /Medio		Carolyn R.	Taylor				June 1	7, 2006	2100 M
	Examir		4a. Fecility Name (If not institution, giv	· ·		4b. City, Town,	or Location of Dea		4c. County of Deat	
п			Fort Washingt	on Hospital	L	Fort 1	Washing	ton	Prince	Georges
	Funeral		Social Security Number 6. S	Sex 7. Age (In y	rs. last birthday)	If Under 1 Year Months Days			9 Birt	hplace (State or Foreign untry)
	Director		242-66-7863	ILIM ZIGHF	61 Yrs.	52,0	1100.0	Sept.5		* *
	pug *		Usual Residence of Decedent  10a. State 10b. County	10c.	City, Town or Lo	cation				10d. tnside City Limits
	Aaryl Feho	5	MD							1⊠Yes 2 No
	the 1	ect	MD PG  10e. Street and Number		Oxon	10f. Zip Code		1	Og. Citizen of What Co	
	a or	ā		Dadis				'		,
	Jeath ms 2:	Funeral Director	7209 Abbington	12. Was Decedent Ever in	1 U.S. 13.1		745 Hispanic Origin? (S	Specify Yes or No-	United S	tates
മ	or Ite	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 X No	'	f Yes, specify Cub	oan, Mexican, Puer	to Rican, etc.)	Black, White	
21215-0036	within 72 hours after death with the Maryland ene. then "naturel", or items 23a or 28e-f ehow the Medical Examinar must be incitified at	Completed by	3 ☐ Widowed 4 Z Divorced	If Yes, Give Year or Dates:		1 □ Yes 2 🔯 No	Specify:		Specify: B1	ack
2-0	72 hc	etec	15. Decedent's Ed (Specify only highest gra	ducation	16a. Deced	dent's Usual Occu	pation during most of wo	rkina	16b. Kind of Business/	
2	ithin	ld u	Elementary/Secondary (0-12)	College (1-4or 5+)	life.	DO NOT use retire	ed)			
7	led w lygier her ti	Ö		3	Procu	rement	Admini		DC Gove	rnment
and	be fi	Be	17. Father's Name (First, Middle, Last,					me (First, Middle, M		
Maryland	hould d Mer mark matic	မ	Edward Chandl  19a. Informant's Name/Relationship (		405 14.75			a G. Fou		
<u>s</u>	d 2 s th an t7 is 1	V. I			7209	Abbino		u <i>rai H</i> oute Number, LVC	City or Town, State, 2	îp Code)
စ်	Heel Heel tem		Monica McCraw  20a. Method of Disposition		D. Place of Dispo	sition (Name of	MD. 20	745 Date	20c. Location - City or	Fown State
altimore,	ages ant of it: If I		1 ⊠Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specification 5 ☐ Other (Specification )		-	natory or other pla	· 1			
	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Heelih and Mentel Hygiene. Department of Heelih and Mentel Hygiene. any injertent: If Item 27 is marked other then "naturel; or items 23a or 28e-f ehow any injerty or other treumatic event, the Medical Examinar must be rediffed at once.		21. Signature of Funeral Service Licer	-	Lesul Le	. Name and Addre	Cem. 6/2	22/06	Clinton, Edwards	MD.
ñ	Pergena	ar a	Janico 8	dwards						
			23a. Part . Enter the disease, or com	plications that caused the de	eath. Do not ente	er the mode of dyi	ng, such as cardia	c or respiratory arre	Sulliano	MD. 20746 Approximate
П	Physician		shock, or heart failure. List only trimediate Cause (Final	_						Interval Between Onset and Death
Н	/Medical		disease or condition resulting in death)	a. Convulsi  Due to (or as a cons						
	Examiner		Constantially list and distant	b_Alzheime	r Deme	ntia				
	D =	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	Due to (or as a cons						
	ecuta ind trans	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c						
Ĉ,	icate be executad physician and s the burial-transit	Ü	resulting in death) cast	Due to (or as a cons	equence of):					
28/60	licate t physic s the b	edicai		d						
_		/Me	IF FEMALE:	23c. tf yes, outcome of preg						
ROX	death certifi e attending d for use as	ian	23b. Was decedent pregnant in the past 12 months?	1 ☐ Live birth 2 ☐ Fe	etal death 3	Ectopic pregnanc	у		23d. Date of delin	very Day Year
j	0 0 0	Physician/Me	1 ☐ Yes 2 ☐No 9 ☐ Unknown	9□Unknown	1002(11 5	Other (specify) _				
J.	law requires that the as been signed by th 2 should be detache		Part II. Other significant conditions of	ontributing to death but not r	esulting in the ur	iderlying cause giv	ven in Part I.	23e. Did tob	acco use contribute to	the cause of death?
Vital Records,	n sign	ed by	Hypertension					1 □ Ye	s 2 □No 3 □ Pro	babiy 4 XUnknown
8	s been si	jete						24a. Was an	24b Were aut	opsy findings available
ř	0 - 0	Completed						autopsy	prior to co	omptetion of cause of
<u> </u>	iclan: Th certificate rector, pag	0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes 2 ath (Check only one	No 1 ☐ Yes	2LX-No
	d is	10 B	examiner? 1 ☐ Yes 2 🌠 No	Hospital: 1tnpatient 2	XER/Outpatient	3□ DOA O#			nce 6 Other (Spec	(fv)
0	ding Ph h. After th funeral		27. Manner of Death 1 SNatural 5 ☐ Pending	28a. Date of tnjury (Month, Day Yeer)	28b. Time of Injury	28c. trijur		28d. Describe ho		,,
<u>0</u>	Attending r death.	atic	2 Accident investigation	1			Yes 2 □No			
=	tal or Attendius efter death.  I Director: All Bed in by the fu	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At building, etc. (Spe	home, farm, stre	et, factory, office		28f. Location (Str. City or Town,	eet and Number or Rui State)	al Route Number,
_	urs e			<u>N</u>						
	Hospital or     24 hours efter     Funeral Directory filled in	Medical	29a. Certifier (Check only one)  1 XCertifying Ph 2 Medical Exam	ysician: To the best of my k niner: On the basis of exami and manner stated.	nowledge, death nation and/or i <i>n</i> v	occurred at the tile estigation, in my o	me, date and place opinion, death occu	, and due to the ca rred at the time, da	use(s) and manner as t te and place, and due t	stated. to the cause(s)
	within 2 To the F complete	Me	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Month,	Dey, Year)
-			Aranina W	wa.		D481	158	т.	uly 7, 20	206
1	5	-	30. Name and address of person who	completed cause of death (it	em 23a) (Type, f	Print)				
			SISOM OSIA	16192 0	YDN t	1166	RD #5	DO DY	らるけら	ms 20.74
	Star Registra		31. Date filed (Month, Day, Year)	32. Registrar's Sig	nature					

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Doris M. Thompson July 6, 2006 4:25 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Anne Arundel Medical Center Annapolis Anne Arundel If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. 5. Social Security Number 6 Sex 7. Age (In yrs. last birthday) **Funeral** 8. Date of Birth (Month, Day, Year) Birthplace (State or Foreign Country) 1 ☐ M 2 💢 F Director 215-18-5312 Yrs 3/6/1923 Maryland Usual Residence of Decedent 10a State 10b County 10c. City, Town or Location 10d. Inside City Limits or 28a-f ahow I7 is marked other than "natural", or Itama 23a or 28a-1 ahov traumatic avent, the Madical Expratater must be notified at Director 1 ☐ Yes 2 X No Maryland | Anne Arundel Annapolis 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1582 Lodgepole Ct. 21409 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 MNo If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 72 hours efter 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛛 No White Completed by Specify: Specify: 3 ☐ Widowed 4 ☐ Divorced 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry d 2 should be filed within 7; th and Mental Hygiene. 7 Is marked other than "na Elementary/Secondary (0-12) College (1-4or 5+) 12th Real Estate Agent Real Estate 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Sumame) Eva Irene Dietz Millard Taylor 2 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) s 1 and 2 s if Health an item 27 ia Sheila I. Marx/ Daughter 1702 Midland Rd., Edgewater, MD 21037 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State Pages nent of t Important: If its any injury or or spice. 1 Burial 2 Cremation 3 Removal from State Kalas Crematory 7-8-06 Edgewater, MD 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatur Funeral Service Acepses 22. Name and Address of Facility George P. Kalas Funeral Home 2973 Solomons Island Rd. Edgewater, MD 21037 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician Congestive Heart Failure /Medical Due to (or as a consequence of): Examiner Mitral Tricuspid Regurgitation Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Years Due to (or as a consequence of): Examiner The law requires that the death certificate be executed burial-transit Coronary Artery Disease Years attending physicien and for use as the burial-trar resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year P.O. F 4 Pregnant at time of death ed by the a detached f 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown signed b Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, δ Acute and Chronic Renal failure Completed 1 ☐ Yes 2 No 3 Probably 4 Unknown peeu 24b. Were autopsy findings available prior to completion of cause of death? Femur/Tibia Fracture 24a. Was an page 2 s autopsy performed? res 2 XNo certificate 1 ☐ Yes 1 Yes 2 No 25. Was case referred to medical examiner? Be 26. Place of Death | Check only one Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1XYes 2 No ٩ 1 XInpatient 2 ER/Outpatient 3 DOA After the 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28c. Injury at Work? Certification: 28d. Describe how injury occurred 1 Natural 5 Pending investigation death. UNKM Fell from wheelchair 1 ☐ Yes 2 💆 No Director: A 6-1-06 2XXAccident 3 🔲 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) Location (Street and Number or Rural Route Number, City or Town, State) within 24 hours after of To the Funerel Direct completely filled in by 4 Homicide ö SCIPEC

Appell's profit

[XCertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Street 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D58124 7-7-06 101 30. Name and iddress of person who completed cause of death (Item 23a) (Type, Print) Paul J. King, M.D. 2003 Medical Pkwy.#400 Annapolis, MD 21401 31. Date filed (Month, Day, Year) 32. gistrar's Signature State JUL 1 0 2006 Registrar

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar		Certificate	of Death		R	eg. No. 20	106 2343
Physici Medical Exam		1. Decedent's Name (First, Middle,L	*			_	Date of Dea     Month	oth Dav Year	3. Time of Death
Medical Exam	mei	James Carte  4a Facility Name (if not institution, s	er Tilley		4b City, Town	or Location of	July 7, 20	06	2219 hrs
		6365 Hawthorne Drive	give street and hamber)		LaPlata	, or Location C	Death	4c. County of [ Charles	Jeath
Funeral		Social Security Number 6.	Sex 7. Age (Ir	yrs. last birthday)	If Under 1	Year If Unde	er 24Hrs. 8. Date of Bu	rth(MM/DD/YYYY) S	Birthplace (State or DC
Director		219-94-6352	См 2 г 42	2 .	Months [	Days Hours	Min. July	8,1963	cou <b>washingto</b>
Å		Usual Residence of Decedent							
ow any		10a. State 10b. County 10b Char]		City, Town or Loc					10d Inside City Limits
Maryland 28a-f show d at once.	tor	10e. Street and Number	es	Indiar	1 Head				1 Yes 2 X No
more, MD 21215-0036  Pages I and 2 should be filed within 72 hours after death with the Maryland near of Health and Menufal Hygiens and returned Hygiens is marked other than "natural", or items 23a or 28a-f she mri. If item 27 is marked other than "natural", or items 23a or 28a-f she not the traumatic event, the Medical Examiner must be notified at once	Director	6365 Hawthorn	ne Road			640	1	0g Citizen of What USA	Country?
with the 18 23a se noti		11. Marital Status	12. Was Decedent Eve	er in U.S. 13. \	Vas Decedent of	Hispanic Orig	in? ( Specify Yes or No		merican Indian, Black,
death r iten	Funeral	1 X Never Married 2 Marri	Armed Forces?		f Yes, specify Cu	ban, Mexican,	Puerto Rican, etc.)	White, e	
after ral", o	by F		ed If Yes, Give Year	1	Yes 2X			Specify:	White
hours 'natur		15. Decedent's Education (Specify Elementary/Secondary (0-12)			ent's Usual Occu most of working	ipation (Give k	and of work done use retired)	16b. Kind of Busin	ess/Industry
136 hin 72 e than '	ompleted	Clementary/Secondary (0-12)	College (1-4 or 5+)		inter			C	- * . 1
5-0036 iled within 72 Hygiene 1 other than "	Con	17. Father's Name (First, Middle, La	st)	1 10	illitel	18 Mother's	s Name (First, Middle, N	Commer	ciai
21215-0036 uld be filed within 7 Mental Hygiene marked other than event, the Medica	Be	Glenwood Tille	y,Jr.			Haz	el Virgir	ia King	
mid 2 should be feath and 2 should be feath and Mental ten 27 is marked traumatic event,	ď	19a. Informant's Name/Relationship				reet and Num	ber or Rural Route Nun	nber, City or Town, S	itate, Zip Code)
e, MD  I and 2 sho Health and item 27 is	١.	Angel Hindle/S		PO E	Sox 294	, Bel	Alton, MI		
Nore ages 1 at of He t: If it		1 X Burial 2 Cremation 3	Removal from State	crematory or	other place)	-		20c. Location - Cit	y or Town, State
		4 Donation 5 Other Special Signature of Funeral Service Lice	fy: M009	Resurre	ction	Cem.	7/15/06	Clinto	n,MD
Balti permit Departm Imports injury o		1/2.41 ( 5)	huh I	45	AREHAR	T-ECH	OLS FUNER	AL HOME	,P.A.
Physician		23a. Part I. Enter the disease, or confailure. List only one cause on	plications that caused the	death. Do not enter	The mode of ayir	0 X 5 6	7 I A DI AT	est, shock, or heart	0646 Approximate Interval
/Medical ∃xaminer		Immediate Cause (Final disease	<sub>a.</sub> Atherosclerotic Car	diovascular D	isease				Between Onset and Death
		or condition resulting in death)	Due to (or as a conseque	nce of)					
	er	Sequentially list conditions, if any, leading to immediate	Due to (or as a conseque	nce of):					
	Examiner	(Disease or injury that initiated	D						
scuted and transit		events resulting in death) Last	Due to (or as a conseque	nce of).					
ian ial -	/Medical	UNPENDED	AMENDED						
8760, ificate be ex ig physician is the burial	/Mec	IF FEMALE.	23c. If yes, outcome of			<del></del> -		23d. Date of deli	very
certificant		23b. Was decedent pregnant in the past 12 months?	1 Live birth 4 Pregnant at time	of dooth	etal death	3 Ectopic	pregnancy	Month	Day Year
Box (e death or the attenued for use	Physicia	1 Yes 2 No 9 Unknow		or death 5	Other (Specify)				
of Vital Records, P.O. Box 683 ing Physician: The law requires that the death certificate has been signed by the attending timeral director, page 2 should be detached for use as 1		Part II. Other significant conditions	contributing to death but	not resulting in the	underlying cause	e given in Par	t I. 23e. Did tol	pacco use contribute	to the cause of death?
S, P	ed by						1 🗸 Yes	2 No 3 F	Probably 4 Unknown
Division of Vital Records, tat or Attending Physician: The law requires after death all Director: After this certificate has been steel in by the funeral director, page 2 should	Completed						24a. Was a autops		autopsy findings available to completion of cause of
Rec The 1st cate h	E O						perform 1 <b>V</b> Yes 2	ned? death	?
tal   cian:	Be	25. Was case referred to medical examiner?	Hospital.		26 Pla		Check only one)		
of Vi Physi er this	리	1 Yes 2 No 27. Manner of Death	28a. Date of Injury	2 ER/Outpatier				Residence 6 🗸 Of	her: Scene
	ion	1 V Natural 5 Pending	(Month, Day, Year)	26b Time of		ijury at Work? Yes 2 1	172	ow injury occurred	
ivisior or Attend after death Director:	ficat	2 Accident Investiga	280 Place of Injune	At home, farm, str				treet and Number or	Rural Route Number, City
Div ital or urs aft	Certification:	Suicide 6 Could no determine	t be		, , , , , , , , , , , , , , , , , , , ,		or Town, St		Rural Rodle Number, City
Division of Vital To the Hospital or Attending Physician: within 24 hours after death To the Funeral Director: After this certif completely filled in by the funeral director,		29a Certifier 1 Certifying Physic	cian: To the best of my kno	wledge, death occi	urred at the time,	date and plac	e, and due to the cause	(s) and manner as s	tarted
To the within To the comple	Medical		er: On the basis of examinat and manner stated	ion and/or investig	ation, in my opanio	on, death occu	urred at the time, date a	nd place, and due to	the cause(s)
	Σ	29b Signature and title of certifier				nse number		29d Date signed (	Month, Day, Year)
			M)		0.0	C.M.E.		July 8, 2006	
185		30. Name and address of person who Laron Locke MD. Assis	completed cause of death stant Medical Examir		n Street, Balt	imore MD	21201		
	ate	31 Date filed (Month, Day Year)	32 Fegistrar's Sig	onature.					
Regist	rar	JUL 12	2006 Blown	B. As	2451				

			1 - For State Registrar	State of	Maryla		artmen tificate			nd M		giene Reg. No	7000	23434
	Physici	an	Decedent's Name (First, Middle, Last)	)							2. Date of De. Month	ath Da	y Year	3. Time of Death
	/Media		ERIKA C. VAL	LEY							JULY 9		006	4:48 A M
	Examir	er	4a. Facility Name (If not institution, give						Location of	Death		40	. County of Dea	th
	<u> </u>		WALDORF HEALTH CA					DORF					CHARLES	
34.	Funeral		5. Social Security Number 6. Sex	7. M 2107 F		. last birthday) Yrs.	If Under Months	Days	If Under 2	Min.	8. Date of Birt (Month, Da			thplace (State or Foreign ountry)
40	Director		217-60-5695 Usual Residence of Decedent		78	113.					DEC.14	, 19	27 GE	RMANY
	land ow		10a. State 10b. County		10c. C	ity, Town or Lo	cation							10d. Inside City Limits
	Many Hear	ţ	MARYLAND CHARLES		W	HITE PL	ATMC							XXYes 2 □ No
	r 28g	Director	10e. Street and Number		***	TITE IL	10f. Zip	Code				10g. Cit	tizen of What Co	ountry?
	h with	a D	4225 SOUTH WINDS D	RIVE #32	21		20	695				II	.S.A.	
	dea	Funeral	11. Marital Status	12. Was Decede Armed Force	ent Ever in l	J.S. 13.			spanic Origi	in? (Spec	cify Yes or No- Rican, etc.)		14. Race - Ame	
9	or it		1 Never Married 2 Married	1 ☐ Yes 27 If Yes, Give			Yes 2		Specify:	rueno r	ncari, etc.)		Black, Whit	
5-0036	ural',	d by	3 ☐Widowed 4 ☐ Divorced	Year or Date	s:			M-2N. *°	ороспу.				Specify: WH	ITE
,	within 72 hours after death with the Maryland ene. than "natural", or iteme 23e or 28e-f show ta Mauleal Examirer must be nuttied at	Completed	15. Decedent's Edu (Specify only highest grade			16a. Deced	kind of wor	k done d	urina most o	of workin	g	16b. K	ind of Business	/Industry
12	withiv ane. than	ш	Elementary/Secondary (0-12)	Coltege (1-4d	or 5+)	1	OO NOT us MEMAK		,			OLI	N HOME	
2	Hygie Hygie other	ပိ	1 Z 17. Father's Name (First, Middle, Last)			1101	TLI IAIX		18 Mother	's Name	(First, Middle,			
an	e d fa	o Be	PAUL MARCHEWKA							A GR		Maidell	Sumamer	
<u> </u>	should ind Men in marke umatic	To	19a. Informant's Name/Relationship (Ty)	pe. Print)		19b Mailin	n Address	(Street a				r City o	or Town, State, 2	Zin Codal
<u>ω</u>	s 1 and 2 should f Health and Mer item 27 is marke other traumatic		RITA BEARDEN (DA						STREE			-		DA 33904
Baltimore, Maryland 2121	s 1 a f Hea item othe		20a. Method of Disposition		20b.	Place of Dispos	sition (Nam	e of			ate		cation - City or	
Ê	Pages nert of int: If it		1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from Sta	ete NA	cemetery, cren ATIONAL	-	,		II.Y	17. 200	16	FALLS C	HURCH, VA
alti	permit. Pag Department Importent: I any injury o		21. Signature of Funeral Service License	90	,	22	. Name and	d Address	s of Facility	DEMA	INE FUN	ERA	L HOME	
ñ	8 9 5 6 8		offana &	1 3	on	0 52	20 S.	WAS	HINGTO	ON S	TREET A	LEX	ANDRIA,	VA 22314
			23a. Part1. Enter the disease, or compli- shock, or heart failure. List only on	cations that caus	sed the dea	ith. Do not ente	or the mode	of dying	, such as ca	ardiac or	respiratory ar	rest,		Approximate Interval Between
	Physician		fmmediate Cause (Final disease or condition	11:00 00		C-031	101	113	11. P.	1 -0 3		int	astase	Onnet and Darth
	/Medical		resulting in death)	Due to (or	as a conse		Coc	CUL	ia a	as	200 M	Len	asiasa	
ı	Examiner		Sequentially list conditions, b	1										
	p is	Examiner	it any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or	as a const	quanta of).								
	and -tran	каш	that initiated events resulting in death) Last	Due to (or	_		-							
3/60,	be executed sicien and burial-transit			500 (0)	as a conse	quence or):								
B	physicate physicate	Physician/Medical	d											
×	death certific e attending p id for use as f	We	IF FEMALE:	3c. ff yes, outcon	ne of precn	ancv								
X R Q	atter 1 for u	clar	in the past 12 months?	1 ☐ Live birth 4 ☐ Pregnant	2 🗌 Feta	aldeath 3□	Ectopic pre Other (spe						23d. Date of deli Month	Nery Day Year
o.	that the dended by the second of	hys	1  Yes 2  No 9  Unknown	9□ Unknown										
T	requires that the een signed by th hould be detache	by P	Part If. Other significant conditions con	tributing to death	but not res	sulting in the un	derlying ca	use give	n in Part I.		23e. Did to	bacco u	se contribute to	the cause of death?
ecords,	w require been sig should b	pa									1 🗆 Y	es 2[	□No 3□Pro	obably 4 Onknown
ပ္တ	law re as bee 2 sho	Completed									24a. Was a	ın	24b. Were au	topsy findings available
r	The lay sate has page 2	Eo									autops	med?	prior to death?	completion of cause of
	stcien: Th certificate rector, pag	Bec	25. Was case referred to medical						26. Place of	f Death	1 ☐ Yes Check only or		1 🗆 Yes	2 0
O TO	Physic this ce al direc	2	examiner? 1 Yes 2 No	ospital:	atient 2	ER/Outpatient	3 DO/	Other					3 □Other (Spec	cifv)
0	ding Ph h. After th funeral	on:	27. Manner of Death  1 Natural 5 Pending	28a. Date of fr (Month, L	njury Da <i>y Year)</i>	28b. Time of Injury	28	c. Injury Work			3d. Describe h			
Vision	tendi feath. tor: A the fu	cati	2 Accident investigation				М		es 2 □ No	0				
$\frac{3}{2}$	il or Attending Physicien: after death. Director: After this certifica d in by the funeral director.	Certificati	3 Suicide 6 Could not be determined	28e. Place of building,	Injury - At h etc. (Speci	iome, farm, stre	et, factory,	office		28	If. Location (S City or Tow			ral Route Number,
ב	oitel o													
	To the Hospitel or Ai within 24 hours after of To the Funerel Direc completely filled in by	edical	29a. Certifier  (Check only one)  1 Certifying Phys 2 Medical Examin	i <b>er</b> : On the basis	of examina	owledge, death ation and/or inv	occurred a estigation,	t the time	e, date and p nion, death	place, an	nd due to the c	ause(s) ate and	and manner as	stated. to the cause(s)
	thin 2 the omple	Med	57.07	and manner	stated.			License						
	2 2 8		29b. Signature and title of certifier						6949			ou. Dal	e signed (Month	, Day, 18a1)
	(3)	-			f doc+h /fr	m 22a) /T						+	11/02	>
	Je.		30. Name and address of person who cor BAIG KAMAKSHI 66	apieted cause of		COMMUNICATION	etet obert mit			NTS C	0616	- 1		
	Sta	е	31. Date filed (Month, Day, Year)	32. Regis	trar's Sign	#102 L	AFLAL		AKYLA	ND_2	unah			
	Registra	S	JUL 1 1 2006	en to	14									

	•	For Stata Registrar		State o	of Ma	ryland	/ Depa	artment o	f Healf of Dea	th and M ath	Mental Hy	ygiei Rag.	4000	06	23435
Physicia /Medica		1. Decedent's Name (First, Middle Merl Watt									2. Date of D Month July		Day 3 2	Year 006	3. Time of Death 3:59 P M
Examine		4a. Facility Name (If not institution  Doctor's Commun						4b. City, Tow Lanh		tion of Death	, , , , , , , , , , , , , , , , , , , ,		4c. County Princ		orge
Funeral Director		5. Social Security Number 045-05-9113	6. Sex	vl 2□F	7. Age	(In yrs. las	t birthday) Yrs.	If Under 1 Ye Months Da	ar If Ur	nder 24 Hrs. urs Min.	8. Date of B (Month, D	ay, Ye	ar)	9. Birthp Coun	lace (State or Foreign htry) Virginia
Maryland s-f show	tor	Usual Residence of Decedent  10a. State 10b. County  Maryland Prince	Geo	rge		10c. City, 1		cation						1	0d. Inside City Limits 1 X Yes 2 □ No
ath with the 23a or 28s	rai Director	10e. Street and Number 3105 Trinity Dr						10f. Zip Cod	0715			10g. USA	Citizen of W	/hat Cour	ntry?
urs after de al', or items	by Fur	11. Marital Status  1 □ Never Married 2 □ Marr  3 ▼ Widowed 4 □ Divorced		. Was Dec Armed Fo 1X Yes If Yes, Gi Year or D	orces? 2 ⊟ N ve	• 1937 • 1936	-   '	Was Decedent f Yes, specify ( 1 ☐ Yes 2√2)	Cuban, Me	c Origin? (Spoxican, Puerto ecify:	ecify Yes or N Rican, etc.)	0-		k, White,	en Indian, etc. ite
permit. Pages 1 and 2 should be tiled within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural", or items 23a or 28a-f show any injury or other traumatic event, If a Medical Evantrat must be notified at once.	Completed	15. Decedent (Specify only highes Elementary/Secondary (0-12)			1-4or 5-		(Give life. I	dent's Usual Ockind of work do DO NOT use re rpenter	ne during tired)	most of work	ing		. Kind of Bu		
uld be tiled Aental Hygie rked other tic event, the	To Be Co	17. Father's Name (First, Middle, Stanley Watts					Va	Tpencer	18. M	Mother's Name	e (First, Middle Unkno	e, Maio			dustry
l and 2 sho fealth and h m 27 is ma her trauma		19a. Informant's Name/Relations! Georgia Tidler/						ag Address (Str Hillcr ille, M				T			
it. Pages 1 intment of H ortant: If ite njury or ot		20a. Method of Disposition  1 ⊠ Burial 2 □ Cremation  4 □ Donation 5 □ Other (S)  21. Signature of Funeral Service	pecify)	moval from	State	cem	Linc	sition (Name or natory or other oln Cen	place) neter	y 7/8/	2006		Location - (		wn, State aryland
Department Department	-	23a. Part1. Enter the disease, or	Complica	ul ations that of	Laused caused	the death.	_ 52	of Bins	oln ensb	Funera urg ka	1 Home ., brei		ood, M	D 2	0722 Approximate
Physician /Medical Examiner		shock, or heart failure. List Immediate Cause (Final disease or condition resulting in death)	only one	cause on e	SE	e. EPSI consequer	S								Interval Between Onset and Death
	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Lisease of injury that initiated events	b.	Due to	-	EME		A							
icate be executed physician and sthe burial-transit	dicai Exa	resulting in death) Last	d.	Due to	(or as a	consequen	nce of):								
attending tor use as	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1  Yes 2 No 9 Unknown	230	1 Live b	oirth 2 nant at t	of pregnancy 2 ∐Fetal de ime ot deat	ath 3	Ectopic pregna Other (specify					23d. Date Mon		ry Day Year
w requires that been signed b should be deta	2	Part II. Other significant condition  HYPERT (				t not resultir	ng in the ur	nderlying cause	given in P	art I.				bute to th	e cause of death?
sicien: The law rescentificate has be irrector, page 2 sho	Completed										24a. Was auto per 1 Yes	psy ormed	pr de		osy findings available inpletion of cause of
s certif	o Re	25. Was case referred to medical examiner?  1 Yes 2 No		spital:	npatier	nt 2∏ EB	/Outpatien	t 3 DOA	Other		me 5□Res		€ □Otho	r (Casa)	.i
To the Mospitel or Attending Physicien: within 24 hours after death. To the Funerel Director: After this certific completely tilled in by the funeral director.	ation: 1	27. Manner Death  1 tural 5 Pendin 2 Accident investig	ation	28a. Date		/ 28	b. Time of Injury	28c. l	njury at Vork?		28d. Describe				,
To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely tilled in by the	Certification:	3 Suicide 6 Could r 4 Homicide determ	beni	buildi	ing, etc.	. (Specify)		eet, factory, offi			City or To	wn, Sta	ate)		l Route Number.
ithin 24 hos o the Fund ompletely t	Medical	29a. Certifier (Check only one)  1 Certifyin 2 Madical I	Examine	r: On the b	asis of (	exa <i>m</i> ination	and/or in:	occurred at the restigation, in m	e time, dat iy opinion, ense numl	death occurr	and due to the ed at the time,	, date a	(s) and man and place, and Date signed	nd due to	the cause(s)
36		30. Name and address of person		pleted caus		ath (Item 23	Ba) (Type	De		095	5 1		7/5	106	, , ,
State	e	6510 KQ 31. Date filed (Month, Day, Year)		40	run	ACC r's Signature	Q	River	dol	e ma	<u> 2</u> c	277	37		
Registra	r	JUL 0 7 2006	Bon	ا سا	15	Span	4								

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death <sup>Day</sup> 2006 **Physician** July William Waterhouse Williamson 8, 5:45AM M /Medical 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Sunrise Assisted Living Frederick Frederick If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Y) 9-1-1933 **Funeral** 9. Birthplace (State or Foreign Months 1**X** M 2 ☐ F 72 Yrs. Director 018-26-8504 Washington, DC Usual Residence of Decedent the Maryland 10c. City, Town or Location permit. Peges 1 and 2 should be filed within 72 hours after death with the Marylar Depertment of Health and Mental Hygiene.
Important: If Item 27 is marked other than "natural", or Iteme 23a or 28a-f show youry or other traumatic event, the Madical Examiner with be publiced at once. 10a. State 10b. County 10d. Inside City Limits Directo 1X Yes 2 □ No MDFrederick Frederick 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 6351 Spring Ridge #311 21701 by Funeral U.S.A. 12. Was Decedent Ever in U.S. Amed Forces? 1 函 Yes 2 □ No If Yes, Give Year or Dates: Korean Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 No Specify: Specify: 3 Widowed 4 Divorced White Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Government 4+ Diversion Supervisor 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be 2 Samuel Williamson Anne Frances Waterhouse 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Suzan Williamson- Wife 6351 Spring Ridge Apt. #311 Frederick, MD 21701 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 Burial 2 Cremation 3 □ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-11-06 National Crematory Falls Church, VA 22. Name and Address of Facility Edward Sagel Funeral Direction 21. Signature of Fun ral Service Licensee Gr 1091 Rockville Pike Rockville, MD 20852 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Parkinsons Disease /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events <u>Hypertension</u> Due to (or as a consequence of) attending physicien and for use as the burial-transit requires that the death certificate be executed Exam Hypothyroidism resulting in death) Last Due to (or as a consequence of): Box 68760, Physician/Medical Osteoarthritis IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐Pregnant at time of death 5 Other (specify) P.O. ed by the a detached f 1 ☐ Yes 2 ☐ No 9 Unknown 9 Unknown ed by Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Division of Vital Records, s been signer Completed by Depression 1 Yes 2 No 3 Probably 4 Unknown Diabetes Type I 24b. Were autopsy findings available prior to completion of cause of death? page 2 autopsy performed? Dementia certificate 28 No 1 Yes 2₺ No 1 Tyes Physiclan: 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Living Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatient ဥ 1 ☐ Yes 2 🔀 No 3□ DOA After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification; 1 Natural 5 Pending investigation Injury s after death. 1 Yes 2 No 2 Accident filled in by the 3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) To the Hospital or At within 24 hours after d To the Funeral Direct Location (Street and Number or Rural Route Number, City or Town, State) 4 \ Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a, Certifier Medical and manner stated 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D54749 July 10, 2006 3 30. Name and address of person who completed cause of death (Jem 23a) (Type, Print) Allen Reilly 801 Toll House Rd. Suite Dl Frederick, MD 21702 31. Date filed (Month, Day, Year) Registrar's Signature State JUL 11 2006 Registrar

			1 - For State Registrar	State of	Marylaı				ealth a		lental H	ygier Reg. 1	- 7	06	23437
F:		- 29	1. Decedent's Name (First, Middle, L	ast)				-			2. Date of I	Death		V	3. Time of Death
	Physici /Medi		George	Waldman								6,	2006	Year	6:19p M
	Examir		4a. Facility Name (If not institution, g	ive street and numb	er)				Location o	of Death		4	4c. County	of Death	
		100	Montgomery Gener				01ne							omery	7
o.	Funeral Director		5. Social Security Number 6.  112–16–1898  Usual Residence of Decedent	797 · · · · · · · · · · · · · · · · · ·	Age (In yrs	. last birthday) Yrs.	Months Months	Days	If Under: Hours	24 Hrs. Min.	8. Date of 8 (Month, 12-1-1	Birth Day, Yea L925	ar)	9. Birthp Cour New	place (State or Foreign htry) York
9	within 72 hours after death with the Maryland ene. thsn "natural", or Iteme 23a or 28a-1 show ta Madical Exeminations for molified at	Funeral Director	10a. State 10b. County  MD Montgon  10e. Street and Number  14800 Pennfield 0  11. Marital Status  1 □ Never Married 2 Married	Circle Apt 12. Was Decede Armed Force	Sil  t. 212  ent Ever in tass?	J.S. 13.	ring 10f. Z 20 Was Deci If Yes, sp				acify Yes or P	U.	S.A. 14. Rac Blac	What Cour ee - Americ ck, White,	an Indian, etc.
Maryland 21215-0036	I within 72 hours. iene. r thsn *naturel*, it e Mexical Exe	Completed by	3 Widowed 4 Divorced  15. Decedent's (Specify only highest g	rade completed)		16a. Dece	kind of w	ual Occupa	luring most		ng	16b.		Whit	
12	filed with Hygiene. other ther	mo	Elementary/Secondary (0-12)	College (1-4 4+	or 5+)	Econo		,				G	overn	ment	
D	Hyg the		17. Father's Name (First, Middle, Las	•		Doomo			18. Mothe	r's Name	(First, Midd				
<u>a</u>	ould be Mental arked o	To Be	Hyman Waldman					İ	Eva '	Vaic	nan			,	
ary.	should ind Men	-	19a. Informant's Name/Relationship	(Type, Print)		19b. Mailir	ng Addres	s (Street a				ber, City	or Town,	State, Zip	Code) 20906
	and 2 ealth a m 27 is		Eleanor Madeline	Waldman-	wife										ring,MD
Baltimore,	一工る事目		20a. Method of Disposition  1   Burial 2 □ Cremation 3  4 □ Donation 5 □ Other (Spec			Place of Dispo cemetery, cres rbeck N	matorv`or	other place	7 -	-9-0	ate 5		Location. ney, l	City or To	wn, State
Balti	permit. Pages Department of Important: If it smy Injury or o		21. Signature of Funeral S rvice Lic	ensee \							rd Sag Rockv				rection 2
	Physician /Medical Examiner	1	23a. Part1. Enter the disease, or co shock, or heart failure. List on Immediate Cause (Finat disease or condition resulting in death)  Sequentially list conditions,	a. Myocar Due to (or	dial as a consec	Infarct quence of): tery Di	ion		j, such as d	cardiac o	respiratory	arrest,			Approximate Interval Between Onset and Death
,8760,	certificate be executed uding physicien and use as the burial-transit	dical Examine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	<sub>c</sub> Hypert		n									
.O. Box 6	deeth e atter	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnan 9 ☐ Unknown	2 ☐ Feta tat time of c	al death 3	Ectopic p Other (s	regnancy pecify)					23d. Date Mor	e of delive	ry Day Year
rds, P	w requires that the been signed by th should be detache	by	Part II. Other significant conditions Obstructive Slee	contributing to deat p Apnea	h but not res	sulting in the u	nderlying	cause give	n in Part I.						e cause of death?
Vital Record	The law ate has b page 2 s	Completed							<u> </u>	_	24a. Wa auto per 1 🗆 Yes	opsy formed?	d	rior to con leath?	osy findings available appletion of cause of
Ž	Physician: this certific ral director,	Be	25. Was case referred to medical examiner?	Hospital:				Otho			(Check only				
o	spital or Attending Physician: ours after death. leral Director: After this certific filled in by the funeral director.	atlon: To	1  Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2  Accident Investigation	28a. Date of I		28b. Time of Injury		28c. Injury Work	4 🔲 1901	2	ne 5 Res 8d. Describe				)
É	ital or Atte	Certification:	3 ☐ Suicide 6 ☐ Could not 4 ☐ Homicide determine	289. Place of	Injury - At h etc. (Specia	ome, farm, str fy)	eet, factor	y, office		2	8f. Location City or To	(Street a	and Numbe	er or Rural	Route Number,
	the Hos nin 24 h the Fur	ledical	one) 2 Medical Exa	hysician: To the be minar: On the basis and manner	s of examina	owledge, death ation and/or in:	vestigation	n, in my op	inion, death	place, a h occurre	nd due to the d at the time	e cause( e, date ar	s) and mai nd place, a	nner as sta ind due to	ated. the cause(s)
	12 Value of 15 mos	Σ	29b. Signature and title of certifier  Bush	_m				c. License					ate signed	(Month, E	Day, Year)
		- 1	30. Name and address of person who		-		Print)			Cn w 4	20 MT				
100			Burt Feldman, MD 31. Date filed (Month, Day, Year)	22 800	strar's Cian	aturo			rver !	oprii	ıg, MD	209			
7.3	Sta Registr		JUL 11	2006	کر میں	s. do	whi	1							

			1_ For State		aryland / Dep		ith and Mental H	ygiene	221,20
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	Physic /Medi Exami	cal	Sacandra N 4a. Facility Name (If not institution, g	. White		4b. City, Town, or Loc	Month . Six ly	Day Year 9 2006 4c. County of Death	1:25-4 M
P	LABIIII	) 		's Hospital			nham		Coomeria
5	Funeral	900			je (In yrs. last birthday,	If Under 1 Year   If U	Under 24 Hrs. 8. Date of B		George's lace (State or Foreign
3	Director		577-02-3733	1 □ M 2 🔯 F	30 Yrs.	Months Days Ho	ours Min. (Month, E		sh., DC
of	р ,		Usual Residence of Decedent		10.00		, , , , , , , , , , , , , , , , , , ,	10, 19/9 Wa.	olioo DC
2	aryla shov	_	10a. State 10b. County		10c. City, Town or Li	cation		10	0d. Inside City Limits
an	he M 28a-f	Director	DC				lashington		1 XYes 2 No
()	ath with the Marylar 1238 or 288-f show	ä	10e. Street and Number		Here an	10f. Zip Code		10g. Citizen of What Coun	try?
1	eath	by Funerai	3323 - 10th	Place, SE	#'T1		20032	United S	
00	after dea or Itama	E	1 Never Married 2 Married	Armed Forces?	Ever III 0.5. 13.	was Decedent of Hispan If Yes, specify Cuban, Mi	nic Origin? (Specify Yes or Nexican, Puerto Rican, etc.)	lo- 14. Race - America Black, White, e	an Indian, atc.
	5-0036 2 hours after atural', or I		3 Widowed 4 Divorced	1 □Yes 2 X 1 If Yes, Give Year or Dates:		1 ☐ Yes 2 <b>X</b> No <i>Sp</i>	pecify:	Specify: B	lack
	21215-0036 d within 72 hours after death with the Maryland giene. The man "natural", or Itama 23a or 28a-f show the Madical Exatrates must be notified at	ted	15. Decedent's	Education	16a. Dece	dent's Usual Occupation		16b. Kind of Business/Ind	lustry
	within 7	Jpie.	(Specify only highest g Elementary/Secondary (0-12)	College (1-4or 5	life	kind of work done during DO NOT use retired)	g most of working		,
		Completed		1		Child	Care	Priva	ate
V	be fill the double of the fill the double of the fill the	Be	17. Father's Name (First, Middle, La			18.	Mother's Name (First, Middle	e, Maiden Surname)	
t.	aryla should ind Meni market	ုင္		C. Ferguson				ce A. White	
7	Maryland 3 nd 2 should be filed lth and Mental Hyg 27 is marked othe traumatic event,		19a. Informant's Name/Relationship					ber, City or Town, State, Zip	
5	2 4 4 5		Joyce A. Fergu	son/Motner	20b. Place of Dispo		1., Hyattsvil		
	0 0 = =	1 3	1 DrBurial 2 Cremation 3	Removal from State	cemetery, crei	natory or other place)	Date	20c. Location - City or Tov	vn, State
$\prec$	Baltimo	di t	4 ☐ Donation 5 ☐ Other (Spec 21. Signature of Funeral Service Lic	ECTO According			k 7/15/2006	Landover,	MD
	Ba perm Depa Impo any i	Ü.,	21. Signature Ci Puripiai Service Ele	ST 2	TITT "	. Name and Address of	o comare	Funeral Home	1010
			23a. Part1, Enter the disease, or co	mplications that caused	the death. Do not ent			Wash., DC 20	Approximate
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	/Medical Examiner		resulting in death)	Due to (or as	a consequence of):	1.0			ZWEEP
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	8760, ate be executed hysician and he burial-transit	cai		d					
	68' tifficat ig phy as th								
	Box 68 eath certifica attending ph for use as th	IN/M	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of				23d. Date of deliver	v
	Geat deat of for	sicia	in the past 12 months? 1 ☐ Yes ② No	4 Pregnant at		Ectopic pregnancy Other (specify)			Day Year
	P.O.	Physician/Med	9 ☐ Unkno <b>l</b> €n	9□ Unknown					
		by	Part II. Other significant conditions	contributing to death bu	ut not resulting in the u	iderlying cause given in F	Part I. 23e. Did	tobacco use contribute to the	cause of death?
	Division of Vital Records, or attending Physician: The law requires tatler death.  Director: After this certificate has been signed in by the funeral director, page 2 should be a	Completed					1 🗆	Yes PNo 3□ Proba	bly 4 □Unknown
	Pec e law has b	npie					24a. Was		sy findings available pletion of cause of
	f Vital Reyysicien: The lar	Con					perfe	ormed? death?	ANO
	Vital Filician: The certificate rector, pag	Be	25. Was case referred to medical examiner?	Hamilah (2)			Place of Death (Check only	one)	
	Of Phys this al dir	2	1 ☐ Yes 2 No 27, Manner of Death	Hospital: 1 Inpatier				dence 6 Other (Specify)	
	On O ding Ph h. After th funeral	ion	Natural 5 ☐ Pending	28a. Date of Injur (Month, Day	Year) 28b. Time of Injury	28c. Injury at Work?		how injury occurred	
	Viten deatl ctor:	lical	2 Accident investigation 3 Suicide 6 Could not		ry - At home, farm, stre				
	Div	Certification:	4 Homicide determined	building, etc	(Specify)	et, ractory, office	City or To	Street and Number or Rural i wn, State)	Route Number,
	Division To the Hospital or Attending within 24 hours after death. To the Funeral Director: After completely filled in by the funer	ledical C	29a. Certifier (Check only one)	miller. On the basis of	examination and/or inv	occurred at the time, dat estigation, in my opinion,	te and place, and due to the , death occurred at the time,	cause(s) and manner as stat date and place, and due to t	ted.
	To the To the Comple	Mec	29b. Signature and title of certifier	and manner state	iou.	29c. License num		29d. Date signed (Month, Da	
			* Xeinsel	um 1	MI	DETTE	C	3.1.01 0	Coco C
	0		30. Name and address of person who	completed cause of de	eath (Item 23a) (Type. I	Print)	MU Alia	2019 -1, 2	006
	ALC.		7925 Greenw	ey Center	Dr. Green	. 11	20770	cuttino	
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature		1,0	1. )	
	Registr	ar	JUL 1 % 2006 1	oluc K	Shoull !				

Please Type or Print in Black Indelible Ink. Assure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Physician** 0630 Elizabeth Mae Warfield 06 /Medical 4a Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Cambridge Dorchester Dorchester General Hospital 8. Date of Birth (Month, Day, Yeer) If Under 24 Hrs. Hours Min. If Under 1 Year 9. Birthplace (State or Foreign 5. Social Security Number 7. Age (In yrs. last birthday) **Funeral** Days 1□ M 200 Months Maryland Yrs. 218-24-2522 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a State 10b County 1 Nes 2 No Be Completed by Funeral Director Cambridge Maryland Dorchester 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 21613 USA 718 Hughlett Street 13. Was Decedent of Hispanic Origin? (Specify Yes or No-lf Yes, specify Cuban, Mexicen, Puerto Ricen, etc.) 14. Race - American Indian, Was Decedent Ever in U,S. Armed Forces? 11 Marital Status Black, White, etc. 72 hours after 1 Never Married 2 Married 1 ☐ Yes 2 ☑ No Baltimore, Maryland 21215-0020 1 ☐ Yes 2 ☐ No ò Specify 3 ☐ Widowed 4 ☐ Divorced White Year or Dates: 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry be filed within 7 all Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Separator - Packer Shirt Manufacturing 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) permit. Pages 1 and 2 should be f Department of Haalth and Mental F Important: If item 27 is marked or John Samuel Hubbard Huldah Ann Elizabeth Bell 19b. Mailing Address (Street end Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 718 Hughlett St., Cambridge, MD 21613 William Leroy Warfield, Sr./Husband 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 □ Cremation 3 □ Removal from State ŏ MD Veterans Cemetery 7/12/2006 Hurlock, Maryland 4 ☐ Donation 5 ☐ Other (Specify) injury Signature of Funeral Service Licensee 22. Name and Address of Facility Curran-Bromwell Funeral Home, P.A. well 308 High St., Cambridge, MD plant ins that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, one cause on each line. 23a Fart1. Enter me disea e, or complishock, or heart fail e. List only or Approximate Intervat Between et and Death Physician /Medical Immediate Cause (Final disease or condition resulting in death) Examiner Que to (or a a consequence of) Be Completed by Physician/Medical Examiner heam on A A or Attanding Physician: The law requires that the death certificate be executed Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Division of Vital Records, P.O. Box 68760, Due to (or as a consequence of) Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23b. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown 24b. Were autopsy findings avaitable prior to completion of cause of death? 24a. Was an autopsy performed? 2Q100 2000 1 Tyes 1 Tes AC 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: Medicai Certification: To 211 patient 2 ER/Outpatient 3 DOA 1 Yes this 28a. Date of Injury (Month, Dey Year) 28c. Injury at Work? 27. Manner of Death
1 Natural
2 □ Accident 28b. Time of 28d. Describe how injury occurred 5 Pending 1 ☐ Yes 2 ☐ No death. investigation To the Funeral Director: / Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 Homicide within 24 hours certifying Physician: To the best of my knowledge, death occurred at the time, date and place, end due to the cause(s) and manner as stated 2 Medical Examiner: On the basis of exemination and/or investigation, in my opinion, death occurred at the time, date and place, end due to the cause(s) and manner stated. (Check only one) 29b. Signature and title of certifier 29d. Date sigged (Month, Day, Year) 29c. License number 30. Name end andress of person y no completed cause of death (Item 23a) (Type, Print) NARR D.O.

DHMH 16 Rev 6/95

State Registrar 31. Date filed (Month, Day,

ELIZABETH

32. Registrar's Signature

06-05229 Philip Roy Anderson

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		Acquaia:	ate of Death	Reg.	. No.	6 2341
Physicia Medical Exami		1. Decedent's Name (First, Middle,Last) Phillip Roy And	lerson	2. Date of Death Month D July 19, 200		3. Time of Death 2015 hrs
		4a Facility Name (if not institution, give street and number) 3808 Fairhaven Avenue, Apartment 1	4b. City, Town, or Location of Dea Baltimore	th	4c County of Death	
Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last bin 1 X M 2 F 58	hday) If Under 1 Year If Under 24H Months Days Hours M		(MM/DD/YYYY) 9. Birtl Foreigi 1947 Cou	
daryland 28a-f show any 1 at once.	tor	Usual Residence of Decedent           10a. State         10b. County         10c. City, Town           Mary1and         N/A         Balti           10e. Street and Number         10e. Street and Number	more			10d. Inside City Limits 1 X Yes 2 No
ith the Maryland 23a or 28a-f sho notified at once	Director	3808 Fairhaven Avenue Apt. 1	10f. Zip Code 21226	10g.	. Citizen of What Coun	try?
, MD 21215-0036 and 2 should be filed within 72 hours after death with the Maryland tealth and Mental Hygiene. tem 27 is marked other than "natural", or items 23a or 28a-f she traumatic event, the Medical Examiner must be notified at once	by Funeral	11. Marital Status  1 Never Married 2 Married Armed Forces?  1 X Yes 2 No  3 Widowed 4 X Divorced of Yes, Give Year or Pagies:	Was Decedent of Hispanic Origin? (     If Yes, specify Cuban, Mexican, Puerl      Yes 2 X No specify:	Specify Yes or No- o Rican, etc.)	14. Race - Americ White, etc Specify: Whi	
136 thin 72 hours te. than "natur: edical Exami	ompleted b	Elementary/Secondary (0-12) College (1-4 or 5+)	Decedent's Usual Occupation (Give kind of during most of working life. DO NOT use re  Longshoreman	work done	6b. Kind of Business/In	,
more, MD 21215-0036 Pages I and 2 should be filed within 72 ent of Health and Mental Hygiene. Int: If item 27 is marked other than ir other traumatic event. the Medical	BeC	17. Father's Name (First, Middle, Last) Walter G. Anderson	18 Mother's Nam	e (First, Middle, Mai a H. Hard	iden Surname) in	
MD 2. nd 2 should shifth and M m 27 is m. aumatic e	ို	Trina Anderson / Daughter 4	Mailing Address (Street and Number or O9 Pontiac Avenue		er, City or Town, State, e, Maryland	
imore Pages   ment of H tant: If i		1 Burial 2 X Cremation 3 Removal from State cremation		22/2006	Baltimore,	Maryland
Balt Depart full port in jury		23a. Part I. Enter the disease, or complications that caused to death. Do no	22. Name and Address of Facility Go 4001 Ritchie Highw	nce Funera ay Baltim	al Service ore, Maryla	
/Medical Examiner		failure. List only one cause on each line.  Immediate Cause (Final disease or condition resulting in death)  Due to (or as a consequence of):		or respiratory arrest,	snock, or neart	Approximate Interval Between Onset and Death
	ner	Sequentially list conditions, if any, leading to immediate  Due to (or as a consequence of):				
uted id ansit	Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):				
760, cate be execut physician and the burial - tran	/Medical	X UNPENDED X AMENDED	7,28a-f,perME,g858,8/29/	06 TT		
Box 68760, e death certificate be the attending physic ed for use as the bur	siciar	3b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown  2 Unknown	Fetal death 3 Ectopic pregn Other (Specify)	ancy	23d. Date of delivery  Month Da	ay Year
s, P.O. I	<u>S</u>	Part II. Other significant conditions contributing to death but not resulting	in the underlying cause given in Part I.		cco use contribute to th	
	Completed	25. Was case referred to medical	26 Pleased Death (Charle		prior to cor d? death?	ppsy findings available impletion of cause of
Vita hysician this cer	ě	examiner?  1 ✓ Yes 2 No Hospital: 1 Inpatient 2 ER/Ou	26.Place of Death (Check tpatient 3 DOA Other Nursin		sidence 6 🗸 Other S	Scene
ion of ttending P death. :tor: After		1 Natural 5 (Month, Day, Year)	ime of Injury 28c. Injury at Work?  8:10 pm 1 Yes 2 XX No	28d. Describe how	injury occurred	
Division Hospital or Attendia 24 hours after death. Lemeral Director. Lely filled in by the fu	Certification:	3 Suicide 6 X Could not be determined 28e, Place of Injury - At home, fair (Specify) Residence	m, street, factory, office building, etc.	28f. Location (Street or Town, State Baltimore,	et and Number or Rura ) 3808 Fairnav MD	l Route Number, City ven Avenue
To the Hos within 24 h To the Fun completely	edical	P9a. Certifier 1	vestigation, in my opinion, death occurred a	due to the cause(s) at the time, date and	and manner as started place, and due to the o	d cause(s)
J. A.	2	19b. Signature and fittle of certifier	29c License number  O.C.M.E.		ed. Date signed (Month uly 20, 2006	ı, Day,Year)
10 lg		Name and address of person who completed calls of shath (Item 23a) Theodore M. King, Jr., MD. Assistant Medical Exami	ner 111 Penn Street, Baltimon	e, MD 21201		
Sta Registr	_	Date filed (Month, Day, Year)  JUL 2 6 2006  32. Reistrar's Signature,	Barles			

				State of Maryland / Der		•	•	0.01.1.1
200			1- State Amend Item	State of Maryland / Der ms 20b,25 per FH/ver	chinicate of Beath 060	ihb Re	g. No.	23441
	Physici		1. Decedent's Name (First, Middle, La	o arun	500	2. Date of Death Month	Day Year	3. Time of Death
7.	/Medi Examir		4a. Facility Name (If not institution, giv		4b. City, Town, or Location of Deat	-	4c. County of Death	2.27
2	Funeral		Future Care -  5. Social Security Number 6. S			8. Date of Birth	9. Birtho	place (State or Foreign
74	Director		239 · 22 · 5849 1	8   Yrs.	Months Days Hours Min.	8. Date of Birth (Month, Day,	1924 Cour	NC NC
	aryland show	_	10a. State 10b. County	10c. City, Town or	,		1	10d. Inside City Limits
	the Mark	recto	10e. Street and Number		timore 101. Zip Code	10	g. Citizen of What Cour	1 New 2 No
	death with the Maryland ms 23s or 28e-f show rinust be intiffed at	Funeral Director	22 S. Athol	Avenue	21229		NOA	
9	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other than "natural", or items 23e or 28e-f show other traumatic event, the Medical Examinar must be inclified at		11. Marital Status 1 ☐ Never Married 2 ☐ Married	12. Was Decedent Ever in U.S. Armed Forces?  1 ☐ Yes 2 ★No If Yes, Give	<ol> <li>Was Decedent of Hispanic Origin? (S If Yes, specify Cuban, Mexican, Puer</li> <li>Yes 2 No Specify:</li> </ol>	Specify Yes or No- to Rican, etc.)	14. Race - Americ Black, White,	
-00	72 hours natural',	ted by	3 StVidowed 4 ☐ Divorced  15. Decedent's Ed	Year or Dates:	edent's Usual Occupation	1	Specify: 2	dustry
21215-0036	within 7 ene. than "n	Completed	(Specify only highest gra	College (1-4or 5+)	re kind of work done during most of wo DO NOT use retired)	rking	Medical	Office
	e filed al Hygie l other vent,	Be Co	17. Father's Name (First, Middle, Last)	unc		me (First, Middle, M		011100
Maryland	hould b d Menta marked matic e	5	Willie Sma  19a. Informant's Name/Relationship (		Rebe		Scott	
	permit. Pages 1 and 2 should be filed within Department of Health and Mental Hygiene. Important: If Item 27 is marked other than amportant; if Item 27 is marked other than any njury or other traumatic event. The Manance.		William T. Ell	ison/Friend 53	iling Address (Street and Number of Ri Go Cordelia AV		3aHo.MD	21215
Baltimore,	ages 1 int of He t: If Item 7 or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐		position (Name of ematery or other place)	Date 2	Oc. Location - City or To Ballmar	
altin	permit. Par Departmen Important: any injury once.		4 □Donation 5 □ Other (Specification 21. Signature of Funeral Service Licer	/ // **********************************	22. Name and Address of Facility	al Sevuir		
	any english		23a. Part 1. Enter the disease, or com	plications that caused the death. Do not a	Complission Funcy 19-121 South Sty			MD 2/223 Approximate
*	Physician		shock, or heart failure. List only Immediate Cause (Final disease or condition	plications that caused the death. Do not e one cause on each line.	The mode of dying, such as cardial	correspiratory arres	51,	Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a consequence of):				
	B / E	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events	b. Due to (or as a consequence of):				
~	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c				
8760	ate be chysician	cai	(	d				
Вох 68	reartific nding p use as	n/Mec	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcome of pregnancy			23d. Date of delive	an/
	ires that the death certifical signed by the attending phy d be detached for use as th	Physician/Medi	in the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown		☐ Ectopic pregnancy ☐ Other (specify)		Month	Day Year
s, P.O.	s that thy pned by e detac	by Ph		ontributing to death but not resulting in the	underlying cause given in Part I.	23e. Did toba	acco use contribute to th	ne cause of death?
ord	w require been sig should b	eted t	H/N	2/10/2 / 0	(c. A	1 ☐ Yes	2 □No 3 □ Prob	ably 4 Unknown
Division of Vital Records,	aician: The law certificate has b irector, page 2 s	Completed	seur por	25/1 mx H	CM	24a. Was an autopsy perform	ed2 prior to cor death?	psy findings available impletion of cause of
/ital	cian: ertifica ector, p	Be	25. Was case referred to medical examiner?		26. Place of Dea	1 ☐ Yes 2 € ath (Check only one)		2 No
of	Physic r this corral dire	5. To	1 ☐ Yes 2 No  27. Manner of Death	Hospital: 1 ☐ Inpatient 2 ☐ ER/Outpatie  28a. Date of Injury 28b. Time		lome 5 Residen	ice 6 Other (Specify	·)
sion	utending death. ctor: Afte / the fune	atlor	1 Natural 5 ☐ Pending 2 ☐ Accident investigation	(Month, Day Year) Injury	of 28c. Injury at Work?  M 1 Yes 2 No		injuly occurred	
Divis	of or Att after de Direct d in by t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, farm, s building, etc. (Specify)	treet, factory, office	28f. Location (Stre City or Town,	eet and Number or Rura State)	l Route Number,
	To the Hospitel or Attending Physician: The law requires that the death certifical within 24 hours after death. To the Funeral Director: After this certificate has been signed by the attending phycompletely filled in by the funeral director, page 2 should be detached for use as the	Medical C	Check only 2 Medical Exam	ysician: To the best of my knowledge, dea niner: On the basis of examination and/or i	ath occurred at the time, date and place	, and due to the cau irred at the time, dat	use(s) and manner as st	ated.
	othe othe	Med	29b. Signature and title of certifier	and manner stated.	29c. License number		d. Date signed (Month, I	
			Af 2A Zuca	V	D39121	7	7/1/1/2	
	(5)		30. Name and address of person who	completed cause of death (Item 23a) (Type	Law St Ballin	nore 1	10212	0/
	Sta		31. Date filed (Month, Day, Year)	32. Registra's Signature			-	(
	Registr	ar	JUL % O ZUUU	AND CONTRACTOR OF THE PARTY OF				

e of Maryland / Department of Health and Mental	Hygiene)	06	221	1	2
Certificate of Death	£ U	00	Car U *	7 7	f-m
Certificate of Death	Rag. No.				

		•	For State Registrar	State of Maryland		ertificate			Rag.	Em U U U	2041	14
* *	Physici	20	Decedent's Name (First, Middle, Last,					2. Dat	e of Death nth	Day Year	3. Time of Dea 5:20 a	ath
	/Medic			Edith B. I	Воок			I Dooth	Jul 2	21, 2006 Year		М
41.	Examin	er ~	4a. Facility Name (If not institution, give Future	Care Chesapeake			m, or Location o	Arnold			Arundel	
	Funeral Director		213-28-1995	7. Age (In yrs. i	ast birthda Yrs	Months D	ear if Under ays Hours	Min. 8. Dat	e of Birth inth, Day, Ye an 11, 19	9. Birt 920	nplace (State or Fo untry) Maryland	reign
	land land		Usual Residence of Decedent  10a. State 10b. County	10c. City	, Town or	Location					10d. Inside City L	
	e Mary Se-f sho	ctor	Maryland Anne A	rundel			Glen Burnie	)			1 Yes 2	]No
	23a or 26	Funeral Director	10e. Street and Number 7923 Freetown Road			10f. Zip Co	2106			Citizen of What Co	A	
9036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Heath and Mental Hygiene. Importent: If item 27 is marked other then "naturel", or Items 23a or 28e-f show eny injury or other traumatic event, I'm Medical Examinat must be ricillised at 90ce.	by	11. Marital Status  1 Never Married 2 Married  3 X Widowed 4 Divorced	12. Was Decedent Ever in U. Armed Forces? 1 ☐ Yes 2 <b>∑</b> No If Yes, Give Year or Dates:	S. 1	3. Was Decedent II Yes, specify 1 ☐ Yes 2 🗷		gin? (Specify Ye , Puerto Rican,		14. Race - Ame Black, White Specify:	Black	
5-0	"natu	letec	15. Decedent's Edu (Specify only highest grad	cation e completed)	/G	cedent's Usual C ive kind of work of a. DO NOT use r	one durina most	of working		o. Kind of Business/	•	
212	withir jiene. r then	Completed	Elementary/Secondary (0-12)	Cottege (1-4or 5+)	,,,,		hurch Clerk			Simmons Me	monal Baptisi	[
land	uld be fited fental Hyg rked other fic event,	To Be C	17. Father's Name (First, Middle, Last)  Joseph	Stith			18. Mothe	r's Name (First,		or Stith		
Mary	and 2 should like and		19a. Informant's Name/Relationship (7) Regina Brown	pe, Print)		ailing Address (S. 7923 Freeto		len Burnie,		ity or Town, State, 2 Id 21061	(ip Code	
Baltimore, Maryland 21215-0036	Pages 1 ament of He ent: If itsn ury or oth		20a. Method of Disposition  1 ☑ Burial 2 ☐ Cremation 3 ☐ F  4 ☐ Donation 5 ☐ Other (Specify)	Removal from State	emetery, d	sposition (Name or other	place)	07/28		Baltimore,		
Balt	permit. Depart Import eny inj		21. Signature of Funeral Service Licens	1) n Oker!	4	22. Name and A Este 1300	ddress of Facility Brothers I Eutaw Pla	, Funeral Sei ce Baltimor	vice, P. A	A. 1217		
9	Physician /Medical Examiner		23a. Part1. Effer the disease, or complishock, heart failure. List only of Immediate Cause (Final disease or condition resulting in death)	ne cause on each line.	291		dying, such as				Approximate Interval Betwee Onset and Dea	
68760,	icate be executed physicien and sthe burial-transit	Ilcal Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a consequence Due to (or a								
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	Se 50	þ	Part II. Other significant conditions co	ntributing to death but not rest	ulting in the	e underlying caus	e given in Part I.	23		co use contribute to	_/	
Division of Vital Records,	law 2 st	Completed							a. Was an autopsy performed	prior to death?	topsy lindings ava completion of cause	ilable e ol
Vita	Physician: r this certific ral director,	Be	25. Was case referred to medicat examiner?	Hospital:			Other	of Death (Chec				
J of	ig Phys ter this neral di	n: To	27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time Injur		Injury at Work?			e 6 □Other (Specintury occurred	cify)	
ivisio	To the Hospitel or Attending Physician: The within 24 hours after death.  To the Funeral Director: After this certificate his completely filled in by the funeral director, page	Certification:	1 Matural 5 Pending 2 Accident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At he building, etc. (Specify	ome, farm,	М	1 Yes 2 1	281. Loc	cation (Stree y or Town, S	t and Number or Ru tate)	ral Route Number,	
۵	papitel of hours at need D			sician: To the best of my kno								
	the Ho hin 24 the Fu	Medical	one)	nar: On the basis of examina and manner stated.	and/o		my opinion, dea	occurred at th		Date signed (Month		
	To To	-	29b. Signature and title of certifier	M.	-M	1/)	1 507	25	250.	7-21-	2006	
	2		30. Name and address of person who co	ompleted cause of death (Item	1 23a) (Ty)	pe, Print)	11 Mills	11 over	110	MD 2	1108	
i i	Sta Registi		31. Date liled (Month, Day, Year) JUL 2 6 200	32 Registrar's Signa	ture	Carle	y JVA	V OV		,	()	

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death 28 PM **Physician** Month JAY FRANKLIN BROWN 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death HEAL HOUSE ASSISTED LIVING BALTIMURE

If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | MAR. 14,1913 BALTIMORE 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** 1 XM 2 ☐ F 256-30-5153 Yrs. Director 93 GEORGIA Usual Residence of Decedent the Maryland 10a. State 10b. County 10c. City, Town or Location 17 is marked other than "natural", or liems 23e or 28e-f show traumatic evant. It's Modical Examiner must be notified at 10d. Inside City Limits 1 ☐ Yes 2X No MD. BALTIMORE BALTIMORE Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? with 4 236 € 2829 LODGE FARM ROAD 21219 U.S.A. by Funeral death 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes ② No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 14. Race - American Indian, Black, White, etc. 1 Never Married 2 Married 1 ☐ Yes 2 XNo 3X Widowed 4 □ Divorced Specify: WHITE Completed permit. Pages 1 and 2 should be filed within 72 the Department of Health and Mental Hygiene. Important: If item 27 is marked other there any injury or other traumer. 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) LABORER TIMBER 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be ED ပ ELONIS BROWN MINNIEBELLE NICKELSON 19a, Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) LYNDA DAVIS/SOCIAL WORKER 4940 EASTERN AVENUE, BALTIMORE, MD. 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State HOLLY HILL CEMETERY 7/27/06 BALTIMORE, MARYLAND <sup>1</sup> 4 □ Donation 5 □ Other (Specify) 21. Signature of Fun at Strvice Licensee 22. Name and Address of Facility
LILLY & ZEILER
1901 EASTERN AV & ZEILER INC. FUNERAL HOME EASTERN AVENUE, BALTIMORE, MD. 21231 23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final Myocardial **Physician** WEEK resulting in death) /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Examiner the attending physician and hed for use as the burial-transit certificate be exec resulting in death) Last Due to (or as a consequence of); Physiclan/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknow signed by the Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? dementia 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform certificate 1 ☐ Yes Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? 1 ☐ Yes 2 No Other: 4 Nursing Home 5 Residence 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 6 Other (Specify) ASS Stell this 28a. Date of Injury (Month, Day Year) funeral 27. Manner of eath 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred Levera After Hospitel or Attanding Division 1 Natural 2 Accident 5 Pending death. 1 ☐ Yes 2 ☐ No Ficili investigation after death 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide To the Hospitel of within 24 hours at To the Funaral D Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certified 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of deat (July 23a) (Type, Print) 44 to Eastern Ne Balt, MD McNebrey MD Mathews 32 Registrar's Signature 31. Date filed (Month, Day, Year) State Registrar

			1 - For Stata Registrar			ertificate of E		ı	Reg. No.	U 6	23441
	Physic /Med		Decedent's Name (First, Middle, Last     MARY BUSH					2. Date of Dea	Day	Year	3. Time of Death
1	Exami	ner	4a. Facility Name (If not institution, give St. Agnes Hosp	,		Baltimo			4c. County	of Death	
	Funeral Director		5. Social Security Number 6. Se 218-44-2852		(In yrs. last birthday		If Under 24 Hrs. Hours Min.	8. Date of Birti (Month, Day April 5	/, Year)	Coun	llace (State or Foreign htry) RYLAND
	ter death with the Maryland Items 23e or 28e-f show Life must be notified at	ctor	Usual Residence of Decedent		10c. City, Town or L	ocation				1	0d. Inside City Limits 1 XYes 2 No
	3e or 28	Il Director	10e. Street and Number  1401 N LAKEWOOD	አህፑ አውባ	132	10f. Zip Code 2121	2		10g. Citizen <i>o</i> f V		try?
036	72 hours after death with the Maryland insture!; or Items 23e or 28e-f show dical Exami, ar must te routied at	by Funeral	11. Marital Status  1 Never Married 2 Married 3 Widowed 4 Divorced	12. Was Decedent Ev Armed Forces? 1 ☐ Yes 2 X X of If Yes, Give Year or Dates:	ver in U.S. 13	Was Decedent of His If Yes, specify Cuban		acify Yes or No- Rican, etc.)	14. Race Blace	- America k, White, (	etc.
21215-0036	permit. Pages 1 end 2 should be tiled within 72 hours att Depertment of Health and Mental Hygiene. Importent: If Item 27 Is marked other than "natural", or any Injury or other traumatic event, the Medical Exert ADRS.	Completed	15. Decedent's Edu (Specify only highest grad Elementary/Secondary (0-12) 12th grade	cation e <i>completed)</i> College (1-4or 5+	(Giv.	edent's Usual Occupat e kind of work done du DO NOT use retired) EAMSTRESS	tion uring most of worki	ing	16b. Kind of Bu		,
Maryland	ould be file Mental Hy arked othe atic event,	To Be C	17. Father's Name (First, Middle, Last) THOMAS J LEMON			1	18. Mother's Name JANIE	(First, Middle, HUGGINS		e)	
	nd 2 shoalth and 27 is m		19a. Informant's Name/Relationship (Ty Serena Watters/Ni	, ,		ing Address (Street ar McHenry St					
Baltimore,	Pages 1 e lent of Hea nt: If Item ry or othe		20a. Method of Disposition  1XXBurial 2 Cremation 3 A  4 Donation 5 Other (Specify)		20b. Place of Disp cemetery, cre		,		20c. Location -	City or Tox	wn, State
Balti	permit. Depertm Depertm Importer sny Inju		21. Signature of Funds Source Vicens	Louis	2	2. Name and Address VILLIAM C I L206 W NOR	of Facility BROWN COM	AMUNITY			MARYLAND E P.A.
68760,	Physicien end was the burial-fransit as the burial-fransit	ledical Examiner	23a. Part Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, flaty, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a d	NEUIN 0, consequence of):		such as cardiac o	rrespiratory arr	est,		Approximate Interval Between Onset and Death
P.O. Box 6	The law requires that the death certificate has been signed by the attending page 2 should be detached for use as	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	3c. If yes, outcome of 1 □ Live birth 2 (4 □ Pregnant at tin 9 □ Unknown	Fetal death 3	Ectopic pregnancy Other (specify)			23d. Date Mon	of deliver	y Day Year
rds, P	w requires that been signed b should be deta	Ď	Part II. Other significant conditions con	tributing to death but i			in Part I.				cause of death?
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Ĭ	Physician: Th this certificate ral director, pag	Be c	25. Was case referred to medical examiner?  1  Yes 2 No	ospital:			26. Place of Death				
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DIVISION	itel or Atte	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury building, etc. (	Specify)			City or Town	,		
	To the Hospitel or A within 24 hours effer To the Funerel Dire completely filled in b	Medical	29a. Certifier  (Check only one)  2 Medical Examin	ician: To the best of n er: On the basis of ex and manner stated	amination and/or in	n occurred at the time, vestigation, in my opin	date and place, a ion, death occurre	nd due to the ca d at the time, da	use(s) and man ite and place, ar	ner as stai nd due to t	led. he cause(s)
	To the To the Comp	×	29b. Signature and title of Certifler	to	in	29c. License n	5186	5	JULY	22	2006
	Ü		30. Name and address of person who con	npleted cause of deat	h (Item 23a) (Type,	Print)  FIN /(US)	217112	BH	UTIM	URE	
	Sta Registr		31. Date filed (Month, Day, Year)	32. sistrar's						-differine	

				State of Maryla		artment of F tificate of		Mental Hy	giene	0.5	20115
		_	Decedent's Name (First, Middle, Las	st)	Cei	uncate or	Dealli	2. Date of Dea	Reg. No. U	UD	3. Time of Death
	Physic /Med		ADAM CL		BEI			JULY	Day 2	Year 006	945
	Exam	iner	4a Facility Name (If not institution, give	Street and number)	EALTA		4b. City, Town,	or Location of Death A POLIS	4c. County	-	741-1
	Funera		5. Social Security Number 6. Se	ex 7. Age (In yr.	s. last birthday)	If Under 1 Year	If Under 24 H	rs. 8. Date of Birtl	. / <del>-</del>	9. Birthpl	ace (State or Foreign
	Director		139-10-3107	<b>№</b> м 2□ F 93	Yrs.	Months Days	Hours M	in. (Month, Da) Aug 7,	1912	Germ	* *
	ehow		Usual Residence of Decedent  10a. State 10b. County	10c. (	City, Town or Lo	cation				10	od. Inside City Limits
	Many Per el	cto	MD Anne A	rundel	Annapo	olis					1□Yes 2√2No
	15 th	ě	10e. Street and Number			10f. Zip Code			0g. Citizen of \	What Count	ry?
	agh v	Funeral Director	4000 River Cresce	ent Drive 12. Was Decedent Ever in	110 110 11	2140		(Casaita Van an Na	USA		a ledia
5-0020	hours after death with the Maryland ural; or items 23s or 28e-f show at Examiner must be notified at	Š	1 Never Married 2 Married  3 Widowed 4 Divorced	Armed Forces?  1 Yes 2 No If Yes, Give Year or Dates:	H	Yes, specify Cuba	an, Mexican, Pu	(Specify Yes or No- erto Rican, etc.)		e - America ck, White, e :: Wh:	
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ylar	Mente Mente arked	10	Irwin Ross Beile	r			Elizal	oeth Kelse	y Crate	es	
Maryland	12 sho and le ma raum		19a. Informant's Name/Relationship (T	•				Aural Route Number		State, Zip (	Code)
-	f Heelt fam 27 other 1		Barbara Emerick/  20a. Method of Disposition		Place of Dispos	ition (Name of		B Lima, OF	1 45805 20c. Location -	City or Tow	m State
E	8 = 5		1 ☐ Burial 2 ☐ Cremation 3 ☐ I 4 ☑ Donation 5 ☐ Other (Specify)		cemetery, crem	atory or other plac	×e)			on <b>,</b> on rom	, 5.0.15
Baltimore	permit. Pa Departmen Important: eny injury phos.		21. Signature of Juneral Service Licens	Pade, Directo		Ate Adde		d 655 W.	Baltime	ore Si	treet
15	_		23a. Part . Enter the disease, or come shock or heart failure. List only of	fications that caused the dea	ath. Do not ente	r the mode of dyin	g, such as cardi	ac or respiratory arre	est,	- 1	Approximate nterval Between
A	Physician /Medical Examiner		Immediate Cause (Final disease or condition	0	wor	131					Onset and Death
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ono	Attending Physicien: Ir death. ector: After this cartific by the funaral director,	ig	27. Manner of Leath  1 Natural 5 Pending  2 Projector investigation	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work M 1□1	av ? /es 2 □ No	28d. Describe ho	w injury occurre	bd	
Division	al or Attending Physics effar death.  No Director: After this ed in by the funaral d	Certification:	2 Necident investigation 3 Suicide 6 Could not be determined	28e. Place of Injury - At h			2010	28f. Location (Str		r or Rural F	Route Number,
ā	re efter el Dir		4   Homicide	building, etc. (Speci	ny)			City or Town	State)		
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	To the Hospital or Atta within 24 hours ettar de To the Funeral Directo completely filled in by th	2	29b. Signature and title of certifier	and manner stated.		29c. License	number	29	d. Date signed	(Month, Da	ıy, Year)
			K Ka Kosh	h anon	A MD		201	08	7/18	3/0	6
		1	XXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXXX	mpleted cause of death (Iter	n 23a) (Type, P	rint)	LNIT	±222 R	WIE	MAS	0710
	Sta		KAKESH A KOKH  31. Date filed (Month, Day, Year)	3£ Registrar's Signa		1714160/	/٧4	130	LE,	70 2	27/3
	Sta Registr	i.e	1111 9 6 2006	Ell ine of the	S Goos	R. S.					

DHMH 16 Rev 6/95

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. amend items 20a-c, 22 per 1h 8838 8-3-06 vt.
State of Maryland / Department of Health and Mental Hygiene For State Registra Certificate of Death Reg. No. 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) 406 **Physician** aM 2006 Reginald Barksdale 12 ul /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death **Examiner** 1ary/and GieneRal 4050 tal 8-Date of Birth (Month, Day, Year) If Under 24 Hrs. 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6 Sex **Funeral** Hours Min 1 ☑ M 2 ☐ F 64 Yrs. 216-38-3647 25, Virginia Director Apr Usual Residence of Decedent 10b. County 10c. City, Town or Location 10d. Inside City Limits 10a. State or Items 23a or 28e-1 ahow other treumatic event, the Medical Examiner must be notified at 1√2 Yes 2 □ No Director MD Baltimore 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code 21217 USA 2525 Eutaw Place #308 death v Funerai Was Decedent Ever in U.S. Armed Forces? ad 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status filed within 72 hours after Hygiene. 1 Never Married 2 Married Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: Specify: black ģ 3 Widowed 4 Divorced "natural" Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry unk unk permit. Pages 1 and 2 should be filed within 7.
Department of Health and Mental Hygiene.
Important: If itam 27 is marked other than "na eny injury or other treumatic event, the Medie once. Elementary/Secondary (0-12) College (1-4or 5+) 10 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be William Barksdale Beatrice Carroll 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Denise Baines/sister 2021 Kelbourne Road Rosedale, MD 21237 Baltimore, Date 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Metro Crematory, Inc. 7-29-06 21. Signature of Edheral Service Utensee

Ronald S. Wadd Director

22. Crematic est Service to Maryland. Inc.

State Anatomy Board 655 W Baltimore S

Baltimore, MD 2123 299 Frederick Rd.

23a. Part. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Immediate Cause (Fine) Baltimore,Md. 4 □Donation 3 Mother (Specify) in state treet-299 Frederick Rd. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition **Physician** resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner Hospital or Attending Physician: The law requires that the death certificate be executed the attending physicien and ned for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760. Completed by Physician/Medical use as tha IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant in the past 12 months? 3 Ectopic pregnancy Month Day Year 4☐ Pregnant at time of death 5 Other (specify) signed by the all d be detached for 1 ☐ Yes 2 ☐ No 9□ Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 4 Denknown 1 ☐ Yes 2 ☐ No 3 Probably peen 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has director, paga 2 autopsy certificate 2□ No 2 No 1 ☐ Yes 25. Was case referred to medical examiner? Be 26. Place of Death (Check only one) 1 Yes 2 No Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) Inpatient Certification: To 2 ER/Outpatient 3□ DOA this in by the funeral 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred After 5 Pending investigation 1 (DNatural М 1 ☐ Yes 2 ☐ No death. 2 Accident within 24 hours efter deat To the Funeral Director: 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide pelli 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical (Check only one) To tha 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifie 29c. License number 32. Registrar's Strature 30. Name and address of person who comp omig filed (Month, Day, Year)

Registrar DHMH 17 Rev 1/2001

State

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		- For State Criticate of Death legistrar	Re	eg. No. 20	06 2344
Physician Medical Examine	1	1. Decedent's Name (First, Middle,Last) Shelby Jean Burns	2. Date of Dea Month July 22, 20		3. Time of Death 1312 hrs
,		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  700 Fast Ordnance Road  Glen Burnie		4c. County of D	1
Funeral		700 East Ordnance Road Glen Burnie  5 Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24Hrs	8 Date of Bir	th(MM/DD/YYYY) 9	
Director		219 26 8780 1 M 2 X F 68 Yrs. Months Days Hours Min	May 1	4, 1938 F	Countr <b>W</b> . VA.
άμ	-	Usual Residence of Decedent         10c. City, Town or Location           10a. State         10b. County         10c. City, Town or Location			10d. Inside City Limits
nd show a	_ I	Maryland N/A Baltimore			1 X Yes 2 No
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Ulrector	10e. Street and Number 10f. Zip Code	1	0g. Citizen of What	Country?
with the		3603 Everett Street 21226  11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Sp.			merican Indian, Black,
death v	Funeral	1 X Never Married 2 Married Armed Forces? 1 Yes 2 X No	Rican, etc.)	White, e	
rs after ural",	함	3 Widowed 4 Divorced If Yes, Give Year 1 Yes 2 X No specify:  15 Decedent's Education (Specify only highest grade completed) 16a Decedent's Usual Occupation (Give kind of Version of Version Occupation)	work done	Specify V	White sss/Industry
72 hou	Completed	Elementary/Secondary (0-12) College (1-4 or 5+) during most of working life. DO NOT use reti	ired)		
within giene her tha	티.	12th Title Clerk  17. Father's Name (First, Middle, Last) 18 Mother's Name	e (First, Middle, I	Motor \	enicle
215- be filed ntal Hyg ked of	a B	, , , , , , , , , , , , , , , , , , , ,	gauerite		
Z = 2 = 3	2	19a Informant's Name/Relationship (Type, Print)  Lisa Merkey / Daughter  19b. Mailing Address (Street and Number or Barbara Street)  3603 Everett Street			state, Zip Code) vland 21226
re, N I and I Health I item	Ī	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Date	20c. Location - Cit	y or Town, State
Pages ment of tant: I	4	4 Donation 5 Other Specify: Bayview Crematory 7/2.	•		e, Maryland
Balt permit Depart Impor injury	-4	21. Signatu of Fo eral Service Licensee 22. Name and Address of Facility Go. 4001 Ritchie Highway	ay Balt:	imore, Man	ce, P.A. cyland 21225
Physician /Medical	1	23a. Part I. Enter the disease, or complications that caused the st. Do not enter the mode of dying, such as cardiac of failure. List only one cause on each line.	or respiratory arr	est, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)  a. Multiple Injuries  Due to (or as a consequence of).			Dean
	_	Sequentially list conditions, if any leading to immediate Due to (or as a consequence of):			
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated			
id ansit		events resulting in death) Last  Due to (or as a consequence of):  d.			
760, cate be executed physician and the burial - transit	Medical	UNPENDED AMENDED			
8760, ifficate be en ag physicial is the bur		IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy	ancy	23d. Date of del Month	Day Year
cords, P.O. Box 687 law requires that the death certifi has been signed by the attending	Physician	past 12 months?  4 Pregnant at time of death 5 Other (Specify) 9 Unknown			
Records, P.O. Box The law requires that the death icate has been signed by the atte		Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I	23e Did to	obacco use contribut	e to the cause of death?
S, P.			1		Probably 4 Unknown
ord: aw requast been as been 2 shoul	Completed		24a. Was autor perfo		e autopsy findings available to completion of cause of th?
Ze The cate		25 Was case referred to medical 26 Place of Death (Check			Yes 2 No
Vital hysician hysician this cert.	o Be	evaminer?	ng Home 5	Residence 6 🗸	Other: Scene
Division of Vital Records, P.O. optial or Attending Physician: The law requires that to ours after death.  teral Director: After this certificate has been signed by filled in by the funeral director, page 2 should be detact	-	27. Manner of Death 28a Date of Injury 28b. Time of Injury 2 28c. Injury at Work?		how injury occurred truck collision	
ivision or Atten after death Director:	icati	2 Accident Investigation 28e Place of Injury - At home, farm, street, factory, office building, etc.			r Rural Route Number, City
"喜 夏 敖 庄 】 。	Certification:	3 Suicide 6 Could not be determined (Specify) Local Street	or Town, 9 700 East O		Glen Burnie, MD
8 4 5 5	Medical (	29a Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred and manner stated			
₹ <u>.</u> ¥ ₹ 8	ğ	29b Signature and title of certifier 29c. License number			(Month, Day, Year)
0,		30. Name and address on a rison which comileted cause of death (Item 23a)		July 23, 2006	
1,		Susan Hogan MD. Assistant Medica Examiner 111 Penn Street, Baltimore, MD 21	1201		
Sta Registr		31. Date filed (Month, Day Year) 2 6 2006 32. Red strar's Signature			
	-				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month **Dorothy Cartwell Physician** 02:30PM 19 2006 JULY /Medical 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Deeth Examiner Battinove City
If Under 1 Year | If Under 24 Hrs. | 18.
Months | Days | Hours | Min. | N/A Sinai Hospital of Balzimore Birthplece (State or Foreign Country)
 Maryland Date of Birth (Month, Day, Year) Feb 22, 1944 7. Age (In yrs. last birthday) 6 Sex 5. Social Security Number **Funeral** 1 □ M 2 🖔 F Months 212-46-3695 62 Director Usual Residence of Decedent 10d. Inside City Limits the Maryland 10h County 10c. City. Town or Location 10a. State or 28a-f show the Medical Examiner must be notified at 1 Yes 2 No **Baltimore** N/A Maryland Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 21215 2804 Hillsdale Avenue Items 23a Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 Never Married 2 Married 1 Yes 2 No Black natural, or Specify: Specify þ 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Hygiene. Own Home Elementary/Secondary (0-12) College (1-4or 5+) Homemaker permit. Pages 1 and 2 should be filled with Department of Health and Mental Hyglene Important: if Item 27 Ie marked other that any injury or other traumatic event. Ital 2006. 12 18. Mother's Name (First, Middle, Maiden Sumame) Maryland 17. Father's Name (First, Middle, Last) Be Viola Gant Earl Edward Cartwell 2 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 2021 Tudor Drive McDonough, Georgia 30253 Dominique Murphy Daughter Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a Method of Disposition 20c. Location - City or Town, Stete 1 Burial 2 Fernation 3 Removal from State 07/21/06 Catonsville, Maryland Metro Crematory, Inc. \* 4 ☐ Donation 5 ☐ Other (Specify) 21. Signatura f Funeral Service Licens 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 death. Do not enter the mode of dying, such as cardiac or respiratory arrest Approximate Interval Between Onset and Death cations that caused the Part I. Enter the disease, or complications that shock, or heart failure. List only one cause on Immediate Cause (Final disease or condition Physician year Pancieuric cancer resulting in death) /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events Due to (or as a consequence of) Examiner The law requires that the death certificate be executed resulting in death) Last Due to (or as a consequence of) the attending physician Physician/Medical IF FEMALE: If yes, outcome of pregnancy

1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 menths? Day Month 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown been signed by should be detac 23e. Did tobacco use contribute to the cause of death? Part II. Other significent conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, Be Completed by 1 Yes 2 No 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an has autopsy performed2 2 No 2 No 1 Yes this certificate 1 Yes To the Hospitat or Attending Physician: within 24 hours after death.

To the Funeral Director: After this certifica completely filled in by the funeral director, p 26. Place of Death (Check only one) 25. Was case referred to medical Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA Certification: To 28b. Time of Injury 28c. Injury at Work? 28d. Describe how injury occurred 27. Manger of Death 1 Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 Suicide 4 Homicide 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Chack only 29d. Date signed (Month, Day, Year) 29c. License number 29b. Signature and title of certifier July 19, 2006 brene RES-000\_ 1/20 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Hospital of Bultimore Sinai Hao, Liene 32/Registrar's Signature 31. Date filed (Month, Day, Year) Coasti State JUL 2 6 2006 Registrar

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Cartuell

21215-0036

Patient

P.O. Box 68760

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#28b, perff., 2857, 7/26/05 TI State of Maryland / Department of Health and Mental Hygiene / 1 1 1 - For State Registrar Certificate of Death 2 Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) **Physician** Cash Kathu 2040 PM JUL 13 06 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner N Medical Center Baltimore
If Under 1 Year If Under 24 Hrs. University of Maryland 8. Date of Birth (Month, Day, Year) 6. Sex 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** Days Min Hours 215-46-1056 Usual Residence of Decedent 1 M 2 F New Jersey Director 10d. Inside City Limits 10a. State 10b. County 10c. City, Town or Location permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryla Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "natural", or Iteme 23e or 28e-f show the hyliquy or other treumatic event, the Madical Examinar inual be putilled at once. 1 Yes 2 No MD Anne Severn Director 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code tade A Funeral 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11 Marital Status Black, White, etc. 1 Yes 2 No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify. Specify þ 3 ☐ Widowed 4 ☑ Divorced white Completed 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Marketing Sales Manager Automate/Office Prod. 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Lillian Ruth William E. Shinn Smith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Michael A. Rader- fiance 7947 Citadel Dr., Severn, MD 21144 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 Burial 2 ☐ Cremation 3 ☐ Removal from State Meadowridge Memorial Park 7/21,2006 Elkridge, MD 4 □Donation 5 □ Other (Specify) 21. Signature of Funeral service Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, MINC 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, Approx shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Multiple Organ Failure **Physician** /Medical Due to (or as a consequence of): Examiner psis Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (of as a consequence of) Examiner or Attending Physician: The law requires that the death certificate be executed ungemia Due to (or as consequence of) physicien P.O. Box 68760 Completed by Physician/Medical the for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☑ No 5 Other (specify) 4☐Pregnant at time of death 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. Division of Vital Records, 2 No 3 Probably 4 Unknown 1 ☐ Yes 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a. Was an has autopsy performer 1 Yes 22 No efter death.
Director: After this certification by the funeral director, 25. Was case referred to medical examiner?
1. Yes 2 □ No Be 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending investigation NOV 29 05 410 Injury MVC 1 ☐ Yes 2 ☐ No 2 Accident 28f. Location (Street and Number or Rural Route Number, City or Town, State) 6 Could not be 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by 4 Thomicide Jessup Stree within 24 hours e To the Hospital 12 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PARIKIT 1767 101 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BALH GREE N PAR 225 5+ SAUMII 32. Segistrar's Signature 31. Date filed (Month, Day, Year) State 2 6 2006

DHMH 17 Rev 1/2001

Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) Year Month **Physician** 3:30 AM 25 COCHRAN 2006 NLY /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner BALTIMERE Hospice MONIUM STelly MARI If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 9. Birthplace (State or Foreign Country) 5. Social Security Number A. Age (In yrs. last birthday) 6. Sex **Funeral** 1 M 3 2 F 172-20-7851 MAY 17, 192 Director Usual Residence of Decedent 10d. Inside City Limits 10c. City, Town or Location 10a. State 10b. County permit. Pages 1 and 2 should be filed within 72 hours after deeth with the Marylan Department of Heelih and Mental Hygiene. Department of Heelih and Mental Hygiene. Important: If tiem 27 is anxied other then "natural; or iteme 23a or 28a-f show any injury or other treumatic event; Ita Medical Examinar must be notified at 1 ☐ Yes 2 ☐ No MIDDLE RIVER Completed by Funeral Director BALTIMOR 10e. Street and Number 10g. Citizen of What Country? U.S.A 3525 21220 oneysuckie 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 11. Marital Status 1 Never Married 2 Married 1 ☐ Yes 2 ☐ No Specify: Maryland 21215-0036 Specify: WhiTe 3 Widowed 4 Dovorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry 15. Decedent's Education (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4or 5+) FOOD Chain WAITERSS 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be B050 FAYE CLOUSTON HERBERI ٩ Pages 1 and 2 should 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 3525 Honeys ockle LA. MiDDLE RIVER MD 21220 Billy COX Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 20a. Method of Disposition 7/31/06 1 Burial 2 Cremation 3 Removal from State BAYLIEW CoernaTory Balto MO 4 ☐ Donation 5 ☐ Other (Specify) 22. Name and Address of Facility recal Home, PATAULSTELLA FUNERAL HOME, PATS 27 har FORD RD BALTO M 21. Signature of Funeral Service Licenses 1 pm 21234 Stella Approximate Interval Between Onset and Death 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** BREAST CANCER /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): by Physician/Medical Examiner The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of): attending physicien IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 4 ☐ Pregnant at time of death 9 ☐ Unknown 23d. Date of delivery 23b. Was decedent pregnant 3 ☐ Ectopic pregnancy signed by the atte d be detached for in the past 12 months? Month Day Year 5 Other (specify) 1 ☐ Yes 2 No Records, P.O. 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Be Completed 24a. Was an autopsy performe 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 1 ☐ Yes 2 No of Vital completely filled in by the funeral director, 25. Was case referred to medicat examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient 2 EP/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Nother (Specify) HOSPICE ို 1 Yes 2 No 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28d. Describe how injury occurred Certification: 1 X Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident ofter death Director: 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours To the Funeral Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

| Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai 29c. License number 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 2 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) TIMONIUM, MD 21093 2300 DULANEY VALLEY RD. DR. TARIO MAHMOOD 31. Date filed (Month, Day,"Year) State JUL 2 6 2006 Registrar

### 06-05340

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State of	f Marylan	I / Department of H	lealth and Mental I	-lygien

reta Coleman		State of Maryland / Department o  For State Certificate of	f Health and Mental H f Death	lygiene Reg.	No. 200	16 001.5
Physicia ledical Examir	n/	1. Deoden's Name (First, Middle, Last)  ORETA JULIA COLEMAN		2. Date of Death	)av Year	3. Time of Death 3 0
		4a. Facility Name (if not institution, give street and number) 1305 Asquith St.	4b. City, Town, or Location of Death Baltimore		4c. County of Deat	h
Funeral Director	2	5. Social Security Number 7 6. Sex 7. Age (In yrs. last birthday) $2\mu - 50 - 5337$ $1 - M$ $2 + 53$ $4 - 53$	Months Days Hours Mir	_ ^ _	Forei	orthplace (State or gen bountry)
d tow any <u>e.</u>		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Loca  BAHLIM	NPE			10d. Inside City Limits 1 Yes 2 No
th the Maryland 23a or 28a-f show notified at once.	Dire	1305 Aguith St.	10f. Zip Code 21/20/2	10g	Citizen of What Cou	intry?
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene. 27 is marked other than "natural", or items 23a or 28a-f she matic event. the Medical Examiner must be notified at once	Fune	1 Never Married 2 Married Armed Forces? 1 Yes 2 No 3 Widowed 4 Divorced If Yes, Give Year	as Decedent of Hispanic Origin? (See Sec. Specify Cuban, Mexican, Puerton Yes 2 No Specify:		14 Race - Ame White, etc. Specify:	RIACK
36 in 72 hours at han "natural digal Examin	pleted by	Elementary/Secondary (0-12) College (1-4 or 5+)	nt's Usual Occupation (Give kind of nost of working life. DO NOT use ref		6b. Kind of Business HEAQ	/Industry
D 21215-0036 should be filed within 72 and Mental Hygiene. 7 is marked other than natic event, the Medical	Be	17. Father's Name (First, Mighle, Last)	18 Mother's Nam	e (First, Middle )Ma	eiden Surname)	7: 0-4)
a at a at		19a Informant's Name/Relationship (Type, Print)  19a ARU (DEMAN)  20a. Method of Disposition  19b. Mailin  20b. Place of Dispo	Strion (Name of Jemetery,	Date	Or MO	e, Zip Code) 2/2/2/2/ ir Town, State
Baltimore, permit Pages I at Department of He Important: If ite		1 Burial 2 Cremation 3 Removal from State Crematory of 6 4 Donation 5 Other Specify: 21 Spnature of Funeral Service Sciences	Name and Address of Facility	28-00   BEDH C	BAKO, U	WEY, MU
m මූ ප් මූ මූ Physician		23a Part i. Enter the disease, or complications that caused the death. Do not enter failure. List only one cause on each line.	the mode of dying, such as cardiac	or respiratory arres	t, shock, or heart	Approximate Interval Between Onset and
/Medical Examiner		Immediate Cause (Final disease or condition resulting in death)  a Atherosclerotic Cardiovascular Disease or condition resulting in death)	sease			Death
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause			***	
executed an and an and an and an and and and an	I Examiner	(Disease or injury that initiated events resulting in death) Last  Due to (or as a consequence of):  d.				
be be	edical	UNPENDED AMENDED			Tool By the Chiling	
Division of Vital Records, P.O. Box 68760 To the Hospital or Attending Physician: The law requires that the death certificate within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending phy completely filled in by the funeral director, page 2 should be detached for use as the b	51	past 12 months?	estal death 3 Ectopic pregrother (Specify)	nancy	23d. Date of delive	Day Year
O. B. it the de lby the lached f		Part II. Other significant conditions contributing to death but not resulting in the	underlying cause given in Part I.	23e. Did tob	acco use contribute to	o the cause of death?
S, P.O.  irres that the signed by d be detached	ed by	Chronic Alcoholism				obably 4 Unknown
of Vital Records, ng Physician: The law requir After this certificate has been s nneral director, page 2 should t	Completed			24a. Was ar autops perform 1 Ves 2	y prior to ned? death?	
tal Recorician: The law rector, page 2 sh	BeC	25. Was case referred to medical	26.Place of Death (Check			
of Vitaing Physici After this c	To E	examiner? 1 ✓ Yes 2 No    Hospital 1   Inpatient 2   ER/Outpatier	Land Land		esidence 6 🗸 Oth	er: Scene
n of ading Ph. th. : After a	ion:	27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of	1 Yes 2 No	25d Beschibe III	William y occurred	
Division pital or Attendir ours after death. teral Director: △	Certification:	2 Accident Investigation 3 Suicide 6 Could not be determined (Specify)  28e. Place of Injury - At home, farm, str	eet, factory, office building, etc.	28f. Location (St or Town, Sta		Rural Route Number, City
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	Medical Co	29a. Certifying Physician: To the best of my knowledge, death occ (Check only one) 2 Medical Examiner: On the basis of examination and/or investig	urred at the time, date and place, ar ation, in my opinion, death occurred	nd due to the cause	(s) and manner as stand place, and due to	arted the cause(s)
F % F 00	Me	29b. Signature and title of certifier	29c License number O.C.M.E.		29d. Date signed (M) July 23, 2006	fonth, Day, Year)
4		39. Name and address of person who completed cause of death (Item 23a)		201		
V		# -	nn Street, Baltimore, MD 21	ZU1		
S Regis	tate trar		1			

			For State Registrar		State of M	aryland			nt of H		and M		Reg. No		06		452
	Physicia	an	Decedent's Name (First,	Middle, Last)	( )	0 h						2. Date of De Month	Da		Year	4 : 2 -	ol Death
Fi.	/Medic	al	4a. Facility Name (If not ins	pri,	Clai			4h Cin	Town or	Location of	of Death	07	40		2006 y ol Death		20 PM
	Examin	er	Lincon /	Suldion, give si	+891th	Cani	ter	A	nna	nol	, ' 5					runo	le/
£.	Funeral		5. Social Security Number	6. Sex	7. Ag	ge (In yrs. la	ast birthday)	If Unde	r 1 Year Days	Il Under		8. Date of Bir (Month, Da	th ly, Year)		9. Birth	place (Stat	e or Foreign
	Director		057-01-0	748 /	M 2□ F	96	Yrs.	10101010				Nov 25,	190	)9	New	York	
	land bw		Usual Residence of Deced 10a. State 10b. 0	County		10c. City	, Town or Lo	ocation								10d. Inside	City Limits
	Many Lef et lied s	tor	MD An:	ne Arun	de1		Anna	apol <b>i</b>	s							1 🗆 Y	es 2 No
	ith the	Direc	10e. Street and Number	0				10f. Z	ip Code						What Cou	intry?	
	within 72 hours after death with the Maryland liene. I then "natural", or Iteme 23e or 28e-1 ehow the Medical Examinal must be notified at	Funeral Director	4000 River		C Drive 2. Was Decedent	Cuaria II 6	6 12	Was Das		L401	ain? /Soe	ofy Ves or No	US		ce - Amer	ican Indian	
	item Item	-une	11. Marital Status  1 □ Never Married 2	_	Armed Forces? 1 ☐ Yes 2 ☐	?				n, Mexican	, Puerto I	cify Yes or No Rican, etc.)			ck, White		
21215-0036	ral', or	þ	3 ☐ Widowed 4 ☐ Di		If Yes, Give Year or Dates:			1 🗆 Yes	2 <b>X</b> No	Specify:				Specif	y: wh:	ite ———	
2-0	72 ho	Completed	15. De (Specify only	ecedent's Educ highest grade	ation completed)		16a. Dece (Give	dent's Us	ual Occupa	ation furing most	t of workii	ng	16b. K	and of B	Business/li	ndustry	
121	within ene. than	duc	Elementary/Secondary (	(0-12)	College (1-4or	5+)		gine		/			in	dus	trial		
d 2	H Trys	Be Co	17. Father's Name (First, A	Middle, Last)						18. Mothe	r's Name	(First, Middle					
/lar	Q 22 00 0	To B	Erest Wild	der Cla	rke							Lawren					
Maryland	2 sho and I is ma		19a. Informant's Name/Re Eric Rohr/n		e, Print)							<i>l Route N</i> umb 'akoma					
	s 1 and 2 should f Health and Men Item 27 is marke other traumatic		20a. Method of Disposition			20b. PI	lace of Dispo	osition (Na	ame of			ate				own, State	
nor	ages ant of tt: If it y or o		1 ☐ Burial 2 ☐ Cren 4 🖾 Donation 5 ☐ O	nation 3 □Re	moval Irom State	CE	em <i>etery</i> , c <i>re</i> r	matory or	other place	Θ)							
Baltimore,	permit. Pages 'Depertment of Himportent: If Ite eny Injury or of once.		21. Signature of Funeral S		ade, Dir	ector			nd Addres More	•	Board 2120	1 655 W	. Ва	alti	more	Stree	et
			23a. Part. Enter the dise shock or heart failur	ase, or complic	ations that cause	d the death							rrest,			Approxin	nate Between
	Physician		Immediate Cause (Final disease or condition	e. List offly off			TIVE	o h	00)	it.	fai	lure				Onset an	nd Death
Æ.	/Medical Examiner		resulting in death)	( "	Due to (or as	s a consequ	ence of):				1 4	, - , -				,	
	LAGITIMICI	J.	Sequentially list condition if any, leading to immedia	s, b.	Ren Due to (or as	7	uence of):	JYY								6 1	104745
	uted d ansit	Examine	cause. Enter Underlying Cause (Disease or injury that initiated events	<b>1</b> 1	•												
o,	be executed sicien end burial-transit		resulting in death) Last		Due to (or as	s a consequ	uence of):										
8760,	9 × 9	lical		d													
89 X	leath certificat ettending phy I for use as th	/Me	IF FEMALE:	. 23	3c. If yes, outcome	e of pregna	ncy							23d. Da	ate of deliv	verv	
Box.	death certifica e ettending ph id for use as th	Physiclan/Med	23b. Was decedent pregn in the past 12 month 1 ☐ Yes 2 ☐ No		1 Live birth 4 Pregnant a			□Ectopic □ Other (	pregnancy specify)					M	onth	Day	Year
P.0.	at the de by the e	hys	9 Unknown		9□ Unknown												- ( - ( - ( - ( - ( - ( - ( - ( - ( - (
Records, I	The law requires that the site has been signed by the bage 2 should be deteched.	þ	Part II. Other significant of	conditions con	tributing to death	but not resu	ulting in the u	inderlying	cause give	en in Part I.	•		Yes 2	_	3 Pro	the cause obably 4	Unknown
eco	e law requ has been je 2 shoul	ompleted										24a. Was	psy	24b.	prior to c	topsy lindin ompletion o	gs available of cause of
E B		Con										1 ☐ Yes	200 No	)	death?	2□ No	
Vital	Physician: I this certificat ral director, pa	o Be	25. Was case referred to examiner?  1 Yes 2 No		ospital: 1 □ Inpat	inst 20	ER/Outpatie	nt 3 🗆 [	Oth	1 "		n <i>(Check only i</i> me 5 ☐ Resi		6 🗆 🗆	hor /Snoo		
of		<b> </b>	27. Manner of Death		28a. Date of Inj	jury	28b. Time o		28c. Injun Worl			28d. Describe				uy/	
ion	Attending I r death. ector: After by the funer	atio	2 Accident	Pending investigation	(Mornin, D	ay roar,	пірпу	М		Yes 2	No						
Division	5 5 t 6	Certification:	3 ☐ Suicide 6 ☐ 4 ☐ Homicide	Could not be determined	28e. Place of Ir building, e	njury - At ho etc. <i>(Specif</i> )	ome, larm, st y)	reet, lacte	ory, office			28f. Location ( City or To			ber or Ru	ral Route N	lumber,
	Hos Fur tely	edicai (			ician: To the bes er: On the basis and manner s	of examinal	tion and/or in	vestigation	n, in my o	pinion, dea	th occurr	ed at the time,	date an	d place,	, and due	to the caus	e(s)
	To the within 2 To the comple	Me	29b. Signature and titte of	f certifier	7		1	2	9c. Licensi	e number	57	,	29d. Da	ate signe	ed (Month	Day, Yea	r)
			· Man	1 17	erey	MI	/		0	027	7 //		0 /	//7	/20	70 <b>0</b>	
			30. Name and address of	person who co	mpleted cause of 222	death (Item	23a) (Type,	Print)	Hw	y, C	rot	ton,	m	0 2	2111	14	
	Sta Regist	ate	31. Date filed (Month, Da	y. Year) 2. 6. 2006	32. Regis	trar's Signa	ture	will.				ton,					

			State Amend Item 25 Registrar 23aP	State of Ma ,27,28a-f	aryland <b>per</b>	d / Depa <b>ME,C</b> 8	artmen Tifficati	t of H	ealth a <b>96dh</b> h	and M	ental H	ygiene Reg. No	2	006	23453	
	Physici	an	Decedent's Name (First, Middle, Last     JANET GIBB								2. Date of Month	Day		200b	3. Time of Death 2210 M	
1	/Medic	al	4a. Fecility Name (If not institution, give	street and number)			4b. City,	Town, or	Location o	of Death	JUNI			nty of Death		
	Examili	lei	SINAL 170	SPITA	1		BA	LT.	MOI		CIT	4		N/A		
	Funeral Director		• • • • • • • • • • • • • • • • • • • •	ex	e (In yrs. I 89	last birthday) Yrs.	If Under Months	1 Year Days	If Under Hours	24 Hrs. Min.	8. Date of Month, July	8inth Y 447	17	9. Birthp Coun	lace (State or Foreign try) SCticut	
	land ow		Usual Residence of Decedent  10a. State 10b. County		10c. City	y, Town or Lo	ocation							1	0d. Inside City Limits	
	the Man 28e-f eh	ector	Maryland Baltimo	re	Par	kville	10f. Zip	Code				10g Cit	izen (	of What Coun	1 □ Yes 2 No	
	with with	Ö	8820 Walther Blvd	#3-411				1234					ISA		,.	
	death me 2;	nera	11. Marital Status	12. Was Decedent	Ever in U.	S. 13.				gin? (Spe	ecify Yes or Rican, etc.)		14. F	lace - Americ		
21215-0036	within 72 hours after death with the Maryland ene. then "natural", or Iteme 23e or 28e-f ehow the Mudical Examinar must be notified at	by Funeral Director	1 ☐ Never Married ※ Married 3 ☐ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 (X) If Yes, Give Year or Dates:	<b>(</b> 0		1 Yes		Specify:	i, i deito	rticari, etc.,		Spe		nite	
5-0	72 ho	eted	15. Decedent's Ed (Specify only highest gra	lucation de completed)		(Give	dent's Usua kind of wo	rk done d	during mos	t of worki	ng	16b. K	ind of	Business/Ind	dustry	
121	within ene. then	Completed	Elementary/Secondary (0-12)	College (1-4or	5+)	шө.	Secre					М	anı	ıfactuı	ring	
	be filed ital Hygi od other event,	To Be Co	John Robert Blackburn Christ								Name (First, Middle, Maiden Sumame)					
Maryland	d 2 should th and Mer ?7 ie marke traumatic		19a. Informant's Name/Relationship ( Phillip T Dunk Jr	• • • • • • • • • • • • • • • • • • • •	and		-								Code) nd 21234	
-	s 1 and 2 I Health Item 27 other tr	١.	20a. Method of Disposition		20b. P	lace of Disperent	osition (Nar	ne of	1		Date	7	_	n - City or To		
E	Pages nent of int: If If iry or o		XtX Burial 2 ☐ Cremation 3 ☐ ↑ ☐ Donation 5 ☐ Other (Specify			ster (	emete	ry	i   6	5/27/					necticut	
Baltimore	permit. Page Department of Important; If any injury or once.		21 ignature of Funeral Service Licer	n Kena	kis	) 2	2. Name ar	d Addres							Home Inc. nd 21212	
			23a. Part1. Enter the disease, or com shock, or heart failure. List only	plications that cause one cause on each li	the death	h. Do not en	ter the mod	le of dyin	g, such as	cardiac o	or respirator	y arrest,			Approximate Interval Between Onset and Death	
	Physician		Immediate Cause (Final disease or condition resulting in death)	a Sul	dux	al 1	tem	ati	ma					_	3 Lays	
	/Medical Examiner		resulting in death)	Due to (or as	a consequ											
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	ate be executed hysicien end the burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	C. Due to (or se	2 200000	uana of):						A	4	MEDICAL STA	MINER	
760,	be exec	cai Ex	resulting in additity East	Due to (or as	a consequ	uence or).					1	VV.	V.	MEDICAL		
687	ficate phys s the			_ d							1	PORC	MED			
Вох	death certificat e attending phy id for use as th	Completed by Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	23c. If yes, outcome 1 ☐ Live birth 4 ☐ Pregnant a	2 Feta	Ideath 3	⊒Ectopic pi				CERTIFIC	ATION APPRO	23d.	Date of delive Month	ory Day Year	
P.O.	0 0 0	hysi	9 Unknown	9□ Unknown												
	8 5 0	d by P	Part II. Other significant conditions of the Apartic	1		-	ınderlying d	ause giv	en in Part I		1			_	ne cause of death? ably 4 Unknown	
000	> 0 5	piete	Alzbeins	ers Dis	cos	ع					24a. W	as an utopsy	24	b. Were auto	psy findings available mpletion of cause of	
R	The lav	Com										orformed?		death?	2 No	
Vita	Physicien: The this certificete ral director, pag	Be	25. Was case referred to medicat examiner?	Hospital:				Oth	or		n (Check on					
of	Phys this aldiu	5 7	1X Yes 2 No  27. Manner of Death	28a. Date of Inju	ıry	ER/Outpatie		28c. Injur Wor	4 🗆 🕅		me 5 ☐ R 28d. Descril			Other (Specificurred	y)	
ion	tending Feath. or; After	atior	T ☐ Natural 5 ☐ Pending 2 Accident investigation	June 19		11:20			k? Yes 2√g	No	Subje	ect fe	211			
Division of Vital Records,	l or Atterater designation	Certification:	3 Suicide 6 Could not be determined	e 28e. Place of In building, e	jury - At ho tc. (Specif	ome, farm, st		y, office		8	820 WE	Town State	e) B	lvd. #	Route Number.	
	To the Hospital or Attendi within 24 hours after death. To the Funeral Director, A completely filled in by the fu	ledical C		nysician: To the best miner: On the basis of and manner s	of my kno of examina					nd place,		he cause(s	) and	manner as s		
	vithin o the	Mec	29b. Signature and title of certifier	2					e number			29d. Da	ite sig	ned (Month,	Day, Year)	
	r= > № 0		* Umhn x	my	50			Do	067	80	8	Ju	WE	E 23	, 2006	
			30. Name and address of person who	completed cause of	death (Iten	n 23a) (Type	, Print)							> 211	¬	
	7		25 CRUSS RO. 31. Date filed (Month, Day, Year)	ADS VR. 32. Regist	rar's Sinns	5011	rt 3.	12	0211	195	MIL	us 1	47	) UI	1+	
15.	St Regist	ate rar	IIII 9 6 2006	SZ. Hogist	A Signo	Corne	1.9									

		,	1-	For State Registrer		State o	of Maryla		partme ertifica					g. No.	06	23454
	Physicia	an	1. D	ecedent's Name (First, Middle,	Last)			D	10			2	Date of Death	Day	Year	3. Time of Death
	/Medic Examin		4a. l	-ouse facility Name (If not institution,	give st	eet and nu	ımber)	Duc		, Town, o	r Location o	of Death	10014		ty of Death	1000
				ohns Hopkins E		riew ,	Medica	al Cert		altir er 1 Year	none If Under		O I Dist		N/A	
П	Funeral Director	- 1		ocial Security Number 6-16-8781	. Sex 1 □ I	M 21XF	7. Age (In yr. 84	s. last birtna Yrs	Months		Hours	Min	Date of Birth (Month, Day, AY 14	, 1922	MAR	place (State or Foreign Intrx) YLAND
	D.		_	al Residence of Decedent			100 (	City, Town or	Location							10d. Inside City Limits
	Aaryia f shov	5	iva	. State 10b. County  MD . BA1	.тт	MORE			ALTIM	ORE						1 ☐ Yes 2√2 No
	n the f	Irect	10e	. Street and Number		IIOICE				ip Code			10	g. Citizen o	What Cou	untry?
	23a o	raiD	1	911 DUNDALK						212					S.A.	
	items Items	Funeral Director		Marital Status 1 □ Never Married 2 □ Marrie		Armed F	cedent Ever in orces? 200 No	U.S. 1	3. Was Dec If Yes, sp	edent of H edify Cuba	lispanic Ori an, Mexican	gin? (Specif n, Puerto Ric	y Yes or No- can, etc.)		ace - Amer ack, White	ican Indian, , etc.
920	hours atter death with the Maryland turel', or Itema 23a or 28a-f show al Exeminer must be notified at	by		3  Widowed 4 □ Divorced		If Yes, G Year or I	ive		1 🗆 Yes	2[ <b>X</b> No	Specify:			Spec	ity: W	HITE
5-0	72 8 3	etec		15. Decedent's (Specify only highest	Educa grade	ition completed,	)	/G	cedent's Us ive kind of w e. DO NOT	ork done	durina mos	t of working		16b. Kind of	Business/li	ndustry
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	othe othe	Bec	17.	Father's Name (First, Middle, L	ist)						18. Mothe	er's Name (/	First, Middle, N		me)	
Maryland	should be and Menta marked umatic ev	ဥ	10	RAYMOND MAI  a. Informant's Name/Relationshi				19b M	ailing Addre	c /Street		ARY	MONT A		n State 7	in Code)
Za	s 1 and 2 should f Heelth and Mer item 27 is marke other traumatic			ERNARD FILIP			IEND						BALTI			21222
ore,				. Method of Disposition  MBurial 2 Cremation			20b	Place of Di	sposition (National Contractions)	ame of other plac	ce)	Dat	e 2	20c. Location	n - City or T	Town, State
Baltimore,	Peges tment of tant: If it			4 □ Donation 5 □ Other (Sp.	city)		MOS		-8-60							, MARYLAND
Bal	permit. Pege Department of Important: If any injury or ance.		21.	Signature of Functional Bervice L	cense	P.	for	4	LILLY 700 S	and Addre	ŽĖILI ONKLI	ER IN	C. FUI	NERAL BALT	HOM IMOR	E 21224 E,MD.
ı				a. Part1. Enter the disease, or o shock, or heart failure. List o	omplic nly one	ations that cause on	caused the de each line.	ath. Do not	enter the mo	de of dyir	ng, such as	cardiac or r	espiratory arre	est,		Approximate Interval Between Onset and Death
	Pnysician /Medical	Ň	dis	mediate Cause (Final ease or condition sulting in death)	_ a.	Urc	OSEPS (or as a cons	SUS							-	3days
	Examiner		50	quentially list canditions	ь	200 10	. (0. 40 4 55.15	oquo 017.								
	p € #	iner	cat	quentially list conditions, ny, leading to immediate use. Enter Underlying use (Disease or Injury		Due to	(or as a cons	equence of):								
	sicien an Tes	Examine	tha	t initiated events ulting in death) Last	c.	Due to	(or as a cons	equence of):	-							
8760,	ate be ex nysicien he burial	cai			d.								-			
Ö	eeth certifica ettending ph I tor use as tl	/Med		FEMALE:	23	c. If ves. o	utcome of preg	nancv						234 [	ate of deliv	wery.
. Box	deeth deeth	Physician/M	23	<ul> <li>b. Was decedent pregnant in the past 12 months?</li> <li>1 □ Yes 2 ₩No</li> </ul>		1∏Live 4∏Preg	birth 2 ☐ Fe nantattime o	etal death	3 □Ectopic 5 □ Other (		у				fonth	Day Year
P.0	et the de 1 by the etached	Phys	_	9 Unknown		9□ Unk					- la Danil	_	22a Did tab		atributa ta	the cause of death?
Records,	The law requires thet the deeth certificate be executed ste has been signed by the ettending physicien and repage 2 should be detached for use as the burial-transit	፩	Par	t II. Other significant condition	s cont	nbuting to	death but not r	esuiting in th	e underlying	cause gr	ven in Part i		_	s 2 No	3 ☐ Pro	_/
Reco	The law resete hes be page 2 she	Completed	_										24a. Was ar autops perform	ned2	prior to c death?	topsy findings available completion of cause of
Vital	icien: T certiticet rector, pa	Be	25.	Was case referred to medicat examiner?							26. Place	of Death (	1  Yes 2 Check only on	B)	1 🗆 Yes	20 100
of <	Physicien: r this certition ral director,	မ		1 ☐ Yes 2 No	Ho			☐ ER/Outpa		OA			5 Reside			cify)
		tion:	27.	Manner of Death  1 Natural 5 Pending 2 Accident investig		28a. Date (Mo	nth, Day Year)	28b. Tim Inju		28c. Inju Wo 1 [	rk? ]Yes 2.∐		d. Describe ho	w injury occ	unea	
Division	i or Attending after death. Director: Afte d in by the tune	Certification:		3 Suicide 6 Could n 4 Homicide determine	ot be		ce of Injury - Alding, etc. (Spe		, street, fact	ory, office		28	f. Location (St. City or Town	reet and Nur , State)	nber or Ru	ral Route Number,
_	To the Hospital of within 24 hours af To the Funstral Completely tilled in	Medical Ce	29	(Check only   Medical		er: On the	basis of exam						d due to the ca l at the time, da			stated. to the cause(s)
	To the within 2 To the complet	Med	29	one)  D. Signature and fittle of contriber	1	and ma	nner stated.		2	9c. Licen:	se number		25	9d. Date sign	ned (Month	n, Day, Year)
	->			DUNSKU	W	m	M			RES	5-0	00	-	TULY "	23,	2006
	5		30.	Name and address of person v	no cor	npleted car	use of death (I	tem 23a) (Ty	pe, Print)	lupa	'h -/	0 11	200.00	mx	A 14	2011
	Sta	ate.	31	Date filed (Month, Day, Year)	enn	197	A940 Registrar's Sig	Laste mature	rr /	IVOI	ve, t	ya Itil	nore,	1110	do	4
	Registi				006	The same	april 1	J: 19	parke							

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend item#19a,perff1,0857,7/26/05 II State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death Month Dav Year **Physician** Dixon 4:30 Frances Jacqueline 4/9 2006 23 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Union Memorial Baltimone Hospital If Under 1 Year | If Under 24 Hrs. Months Days Hours Min. 8. Date of Birth (Month, Day, 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex **Funeral** Months 1 ☐ M 2 🛣 F 218.40.7643 02 Yrs. Director Usual Residence of Decedent 10d. Inside City Limits filed within 72 hours after deeth with the Maryland 10c. City, Town or Location 10b. County 10a. State and Mentel Hygiene. Is marked other than "natural", or Itema 23s or 28s-f show reumatic avant, Ite Mudical Exercises must be notified at NIA 1 Yes 2 □ No Baltimore MD Directo 10g. Citizen of What Country? 10f. Zip Code 10e. Street and Number 21218 2208 Barclau USA Street Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces?
1 ☐ Yes 2 → No ff Yes, Give 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 Yes 2 No Specify: Black Specify: 3 Widowed 4 Divorced Year or Dates: 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DQ NOT use retired) 16b. Kind of Business/Industry Efementary/Secondary (0-12) Coflege (1-4or 5+) Housewife NIA 10th grade 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name First, Middle, Last) Pages 1 and 2 should be Lleo Dixon Brown John 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, P) Road permit. Pages 1 and 2:3 Department of Health ar Important: If Itam 27 Is any Injury or other treu Carney MD 21234

20c. Leation - City or Town, State 2423 Harwood DBVOCHU 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20a. Method of Disposition 1 Burial 2 Cremation 3 Removal from State Mt. Zion Cemetem 07/28/06 Baltimore MD 4 □ Donation 5 □ Other (Specify) 22. Name and Address of Pacility Youghn (. Gwlene Tuneral Sewicos 4905 York Road Baltimore MD 21212 21. Signature of Funeral Service Licensee 14 M01363 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death fmmediate Cause (Finaf Heart ongestive **Physician** disease or condition resulting in death) /Medical Due to (or as a consequence of) Examiner Renal Saquentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examine ettending physicien and for use as the burial-transit Attanding Physicien: The law requires that the death certificate be executed that initiated events Division of Vital Records, P.O. Box 68760, $\mathbb Z$ resulting in death) Last Due to (or as a consequence of): Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 23d. Date of defivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4 Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Completed by 1 Yes 2 10 3 Probably 4 Unknown 24b. Were autopsy findings available prior to completion of cause of death?

1 Yes 2 No 24a. Was an autopsy performed? 2 No 1 Yes 25. Was case referred to medical examiner? Be 26. Pface of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 Yes 2 10 Certification: To 1 Impatient 2 ER/Outpatient 3 DOA this After thi 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death 1 CHatural 5 Pending death. 1 Yes 2 No ours after death.

neral Diractor; A
filled in by the fu investigation 2 Accident 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 3 🖺 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 - Homicide To the Hospital o within 24 hours aff To the Funeral DI 25a Centiler 1 Cartifying Physician: To the best of my knowledge, death occurred at the time, date and plane, and due to the name(s) and manner as stated Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier July 123/2006 Jaleed Bolan M.D. AT 2438946 201 E. University Purkway 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) BOLAD M.D. UNION MEMORIAL HOSPITAL BALTIMORE, MO 21218 32 Registrar's Signature 31. Date fifed (Month, Day, Year) State JUL 2 6 2006

DHMH 17 Rev 1/2001

Registrar

State of Maryland / Department of Health and Mental Hygiene. 1 - For State Registra Certificate of Death 2. Date of Death 3. Time of Death 1. Decedent's Name (First, Middle, Last) Month Day Year **Physician** 1330 Frances G. 20 JULY 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner BALTIMORE SAMARITAN GOOD HOLOITAL N/A If Under 1 Year | If Under 24 Hrs. 8. Date of Birth (Month, Day, Year May 05, 19 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Days Months Hours 1 M 2 XF 85 Virginia Yrs 577-22-9816 Director Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10a. State 28a-f show other treumatic event, the Madical Expriner was be notified at 1 Tyes 2X No Md. Baltimore Baltimore Director 10e. Street and Number 10g. Citizen of What Country? 10f. Zip Code ŏ USA 8810 Walther Blvd. #1209 21234 or items 23a Funerai 14. Race - American Indian, Black, White, etc. 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status a filed within 72 hours after de Il Hygiene. other than "natural", or Item 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 ☐ Never Married 2 ☐ Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☑ No Specify: White 3 Widowed 4 □ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Administrative Asst. Federal Government +2 permit. Pages I and 2 should be filed a Department of Health and Mental Hygie Important: If item 27 is marked other I any injury or other treumatic event, In 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) E11a Hash Brammer George 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) 1213 Brookview Rd. Baltimore, Md. 21286 Mr. Robert Davison/ Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☆ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7-22-06 Hilltop Service Co. Towson, Md. <sup>22. Name and Address of Facility</sup>
Ruck Towson Funeral Home,
1050 York Rd. Towson, Md. 21. Signature of Funeral Service Licensee Approximate Interval Between Onset and Death 23a. Part f. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) Due to (or as a consequence of): **Physician** Gastrointestinal /Medical Examiner -45tric Ulcer Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien end s the burial-transit Due to (or as a consequence of); Box 68760. Physician/Medical page 2 should be detached for use as the attending IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 MNo Month Day Year 4□Pregnant at time of death 5 Other (specify) Records, P.O. Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 3 ☐ Probably 4 ☑Unknown Mys (acitial Be Completed 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?
1 ☐ Yes 28 No Anemia autopsy 1□ Yes 2 No To the Hospital or Attending Physician: within 24 hours efter death.

To the Funerel Director: After this certifica 25. Was case referred to medical 26. Place of Death | Check only one examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 ☐ Yes 2 🔀 No 18 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 27. Manner of Death 28b. Time of 28d. Describe how injury occurred 1 XNatural 5 Pending Injury 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 4 - Homicide 🗷 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. Medical 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) RES JULY 20, Z006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Blud Baltimore 5601 Loch Raven Hakin Wyel 32. Registrar's Signature 31. Date filed (Month, Day, Year) State

DHMH 17 Rev 1/2001

Registrar

DAVISON, FRANCES

06-05259 Al Eldamati Please Type or Print in Black Indelible Ink

State of Maryland / Department of Health and Mental Hygiene Çertifiçate of Death EH\_C857 Reg. No. Registrar Amend 2. Date of Death Physician/ Month Day July 20, 2006 Medical Examine 1410 hrs ELDAMATI 4a Facility Name (if not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Sinai Hospital Baltimore N/A 5. Social Security Number 6. Sex Age (In yrs, last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth (MM/DD/YYYY 9. Birthplace (State or **Funeral** oreign Director Months Davs Hours Min 217-62-2201 1 X M 2 87 03/02/1919 Country) EGYPT Usual Residence of Decedent 10a. State 10c. City, Town or Location 10d Inside City Limits MD BALTIMORE BALTIMORE 1 Yes 2 X No permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene.
Important: If lies 75's marked other than "natural", or items 23a or 28a-f she injury or other traumatic event, the Medical Examiner must be notified at once Director 10e Street and Number 10g. Citizen of What Country? 4 TROTTERS COURT APT. #4 U.S.A. 21208 Funeral Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 12. Was Decedent Ever in U.S 14. Race - American Indian, Black, Armed Forces? 1 Never Married 2 Married White, etc. Yes 2 X No Yes, Give Year 3 X Widowed Divorced 1 Yes 2 X No specify: Specify: WHITE ģ 15. Decedent's Education (Specify only highest grade completed) Decedent's Usual Occupation (Give kind of work done 16b. Kind of Business/Industry Completed during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4 or 5+) Mechanical MECHAICAL 5+ ENGINEER <u>TEXILES</u> 17. Father's Name (First, Middle, Last) 18 Mother's Name (First, Middle, Maiden Surname) æ KAMEL ELDAMATI AMINA UNOBTAINABLE 19a Informant's Name/Relationship (Type, Print ) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AMINA WOODS / DAUGHTER STEVENSON ROAD - BALTIMORE, MD 21208 7933 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, 20c. Location - City or Town, State 1 Burial 2 Cremation 3 crematory or other place) Removal from State DRUID RIDGE 07/24/2006 | BALTIMORE, MD Donation 5 Other Specify 21 St. aure of Funeral Service Lice see 22. Name and Address of Facility SOL LEVINSON & BROS., INC. Junson 23a. Part I. Enter the disease, or complications that caused the death. Do not enter the mole of lying, such as cardiac or respiratory arrest, shock, or near performation interval. Physician failure. List only one cause on each line /Medical Between Onset and Sepsis with complications Death Immediate Cause (Final disease Examiner or condition resulting in death) Due to (or as a consequence of): Right leg abscess Sequentially list conditions, Examiner if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): and sician/Medical W UNPENDED physician the hurial -AMENDED item#23a-b, PII,27,28a-f,perME,g858,8/10/06 TT Division of Vital Records, P.O. Box 68760, 23c If yes, outcome of pregnancy 23d Date of delivery 23b. Was decedent pregnant in the 1 Live birth Fetal death 3 Ectopic pregnancy past 12 months? 2 Month Day Year Pregnant at time of death 5 Other (Specify) 1 Yes 2 No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ Fracture of left femur, 1 Yes 2 No 3 Probably 4 Unknown Completed 24a. Was an 24b. Were autopsy findings available Pancreatic mass; autopsy prior to completion of cause of performed' death? certificate Renal failure Yes 2 V No Yes 2 No 25. Was case referred to medical 26.Place of Death (Check only one) Be examiner? Other<sub>4</sub> Hospital: 1 Inpatient ER/Outpatient 3 After this Nursing Home 5 Residence 6 Other 1 🗸 Yes ٩ 27. Manner of Death 28a Date of Injury (Month, Day, Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: 1 Natural subject was scratched by a cat 1 Yes 2 No 5 Pending June 2006 unk 2 X Accident 28e. Place of Injury - At home, farm, street, factory, office building, etc. Location (Street and Number or Rural Route Number, City Suicide Could not be or Town, State) 4 Trotter Ct. Apt 4 Pikesville, MD (Specify) residence Homicide 29a. Certifier (Check only one) Medical Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as started Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated 29b Signature 29c License number 29d Date signed (Month, Day, Year) O.C.M.E. July 21, 2006 Name and address of person who complete cause of death (Item 23a) Susan Hogan MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201 31. Date filed (Month, Day, Year) State 32. Redistrar's Signature 2006 6 Registrar

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene-1 - For State Registrar Certificate of Death Reg. No 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** 2058 Felder 20 Theresa 2006 /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner of Maryland Medical Center Baltimore N/A University If Under 1 Year | If Under 24 Hrs.
Months Days Hours Min. Birthplace (State or Foreign Country) 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) Date of Birth (Month, Day, Year) **Funeral** Months 1 ☐ M 2 € F 213-84-3153 45 Director Jan 31, 1961 Maryland Usual Residence of Decedent with the Maryland 10c. City, Town or Location 10d. Inside City Limits 10h County 10a State ?? ie marked other then "nature!", or lieme 23a or 28a-f ebov traumatic event, the Madical Examinar must be notified at 1 X Yes 2 □ No Baltimore Director Maryland N/A 10g. Citizen of What Country? 10e. Street and Number 10f. Zip Code U.S.A. 1335 West Lafayette Avenue 21206 1 and 2 should be filed within 72 hours after death v Health and Mental Hygiene. em 27 ie marked other then "naturel; or Iteme 23 Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Marned Baltimore, Maryland 21215-0036 1 Yes 2 YNo Specify: Specify: Black þ 3 Widowed 4 Noivorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Safeway Grocery Manager 12 18. Mother's Name (First, Middle, Maiden Sumame) 17. Father's Name (First, Middle, Last) Be Albert Timothy Daniels Susan Brown 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 19a. Informant's Name/Relationship (Type, Print) permit. Pages 1 and 2 Department of Health a Important: if Item 27 ie eny injury or other trai 5921 Plumer Avenue Baltimore, Maryland 21206 DeJuan Felder Son 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a Method of Disposition 1 X Burial 2 ☐ Cremation 3 ☐ Removal from State 07/26/06 Baltimore, Maryland Arbutus Memorial Park 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Estep Brothers Funeral Service, P. A. 1300 Eutaw Place Baltimore, Md 21217 WO ONU 23a. Part: Enter he disease, or complications that caused the death. Do shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death not enter the mode of dying, such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Preumoni **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, any, leading 15 immediate cause. Enter Underlying Cause (Disease or injury Due to (or as a consequence of): Examiner attending physician and for use as the burial-transit The law requires that the death certificate be executed that initiated events resulting in death) Last Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 □Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Virus Immunodeficiency 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ☐ Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No 24a Was an complex 2 No 1 ☐ Yes or Attending Physicien: Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: 1 Inpatient Other: 4 \( \triangle \text{ Nursing Home} \) 5 \( \triangle \text{ Residence} \) 6 \( \triangle \text{Other} \( (Specify) \) 1 Yes 2 No မ 2 ☐ ER/Outpatient 3 ☐ DOA this After this 28a. Date of Injury (Month, Day Year) 28c. Injury at Work? 28b. Time of 28d. Describe how injury occurred 27. Manner of Death Certification: 1 Natural 5 Pending death. 1 Yes 2 □ No investigation Director: / 2 Accident 6 Could not be determined 3 ☐ Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) filled in by To the Hospital or At within 24 hours after To the Funeral Direc 4 | Homicide 29a. Certifier t 📵 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. (Check only one) 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 29c. License number 17417

State Registrar

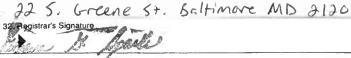
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31. Date filed (Month, Day, Year)

30. Name and address of person who completed cause of death (Item 23a) (Type, Print)

Heas



DHMH 17 Rev 1/2001

7/20/2006

				1 - For State Registrar	State of Maryla		artment of tificate of			giene	23459
		Physic	ian	Decedent's Name (First, Middle, Las.	9	-			2. Date of Dea Month	ath Day Year	3. Time of Death
		/Medi	cal	ALLEN E.	FRIEND				July	21 2006	
•		Exami	ner	4a. Facility Name (If not institution, give				or Location of Death	1	4c. County of Dea	th
	*	Funeral	_	JOSEPH RICHIE H 5. Social Security Number 6. Se		rs. last birthday)	BAI If Under 1 Yea	TIMORE r   If Under 24 Hrs.	8. Date of Birti	N/A	thologo /State or Fourier
	7	Director			DM 2□F	76 Yrs.	Months Day		(Month, Day	r, Year) Co	thplace (State or Foreign buntry) SSOURI
		pu .		Usual Residence of Decedent  10a. State 10b. County	100	02. T			- Juan I.	1930   111	
		ehow	5			City, Town or Lo					10d. Inside City Limits
		the M	Director	MARYLAND BALTIM	ORE	CATO	NSVILLE				1 ☐ Yes 2 No
2		with 3a or		6515 WOODBRIDG	F CIDCIE		10f. Zip Code	1228		10g. Citizen of What Co	ountry?
4		death	Funeral	11. Marital Status	12. Was Decedent Ever in	n U.S. 13. V		Hispanic Origin? (Sp ban, Mexican, Puerto	pecify Yes or No-	U.S.A.	ncan Indian,
=00 AM	9	within 72 hours after death with the Maryland ene. then "neturel", or items 23a or 28a-f ehow he Madical Examinat must be notified at	F	1 Never Married 2 Married	Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give		Yes, specify Cu		Rican, etc.)		
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14	15-	n 72 ho "netur edical	Completed	15. Decedent's Edu (Specify only highest grad	cation e completed)	16a. Deced	ent's Usual Occu	ipation e during most of work ed)	king	16b. Kind of Business	Industry
2	2121	d withir piene. r then	m o	Elementary/Secondary (0-12)  12th grade	College (1-4or 5+) lyr		RAPENUER			DUCTNECC	DEVIET OFMENIE
		e filec I Hyg othe	0	17. Father's Name (First, Middle, Last)	<u> </u>	101411	AFENOER		ne (First, Middle,	Maiden Surname)	DEVELOPMENT
•	/lar	0 2 0 0	To B	NATHANIEL FRIEND				BESSIE	PITTMON	r	
7/21/06	Maryland	and sum		19a. Informant's Name/Relationship (T)	pe, Print)	19b. Mailin	g Address (Stree	t and Number or Rui	ral Route Number	r, City or Town, State, 2	Zip Code)
10		s 1 and 2 of Health Item 27 I		Mandy L. Friend		6515	Woodbri	dge Circl		more, Mary	land 21228
21	Baltimore,	50 - 0		20a. Method of Disposition 1   Burial 2 □ Cremation 3 □ F	Removal from State	. Place of Dispos cemetery, crem	sition (Name of atory or other pla	ace)	Date	20c. Location - City or	Town, State
1	Ħ	it. Pa rtmer rtant njury		4 ☐ Donation 5 ☐ Other (Specify)  21. Signature		ARBUTUS			27-06	BALTIMORE,	MARYLAND
11-	Ba	permit. Page Department ( Important: If any njury or		) / Co	oun		_ZUO W N	ORTH AVEN	UE	FUNERAL HO	ME, P.A.
		Physician /Medical Examiner		23a. Part The the disease, or complished, or heart failure. List only of Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions	Due to (or as a consci	Cancer	r the mode of dy	ing, such as cardiac	or respiratory arr	9St,	Approximate Interval Between Onset and Death
2	8760,	sate be executed whysician and the burial-transit	dical Examiner	Sequentially list conditions, if any, loading to min obliate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a conse						
PIEN,	P.O. Box 6	at the death certifii by the attending p tached for use as	Physician/Med	m the past 12 months? 1 ☐ Yes 2 ☐ No 9 ☐ Unknown	3c. If yes, outcome of preg 1 ☐Live birth 2 ☐Fe 4 ☐ Pregnant at time of 9 ☐ Unknown	otal déath 3∏l f death 5∏	Ectopic pregnand Other (specify) _			23d. Date of deli Month	very Day Year
IT	Records, I	w requires that been signed I should be det	ğ	Part II. Other significant conditions cor	tributing to death but not re	esulting in the und	derlying cause gr	ven in Part I.		oacco use contribute to es 2 □ No 3 Merc	the cause of death?
3		: The law r cate has be page 2 sh	Completed						24a. Was ar autops perform 1 Yes 2	prior to c death?	opsy findings available ompletion of cause of
M	Vital	sician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?	lospital:		0"	26. Place of Death			-11-
776	of	To the Hospital or Attending Physician: The within 24 hours after death. To the Funeral Director: After this certificate his completely filled in by the tuneral director, page	atlon: To	1 Yes 2 No  27. Manner of Death 1 Natural 5 Pending 2 Accident investigation	1 ☐ Inpatient 2 ( 28a. Date of Injury (Month, Day Year)	ER/Outpatient 28b. Time of Injury	28c. Inju			nce 6 thother (Spec w injury occurred	tospice
1	Division	To the Hospital or Attendi within 24 hours after death. To the Funeral Director: / completely filled in by the t	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injury - At building, etc. (Spec	home, farm, stree	et, factory, office		28f. Location (Str City or Town	reet and Number or Rui , State)	al Route Number,
		he Hospi n 24 hour he Funer pletely fill	edical	29a. Certifier (Check only one) 1 Certifying Phys	sician: To the best of my kner: On the basis of examinand manner stated.	nowledge, death on ation and/or investigation	occurred at the ti estigation, in my o	me, date and place, opinion, death occurr	and due to the ca	use(s) and manner as ite and place, and due	stated. to the cause(s)
		To t To t	Σ	29b. Signature and title of certifier			29c. Licens	se number	29	d. Date signed (Month)	Day, Year)
				1 680 MD			D	24170		July 21. 2	206
		3		30. Name and address of person who co	mpleted cause of death (Ite	em 23a) (Type, P	rint)		0 11	July 21, 2 wore MD	
				31. Date filed (Month, Day, Year)	they Hospic 32. Registrar's Sign	e 838	NEL	itaw St	Balti	wore MD	21201
		Sta Registr		JUI 2 6 7	306 Meses	# A	hade!				

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death JMTy 23, ™2006 **Physician** DONALD LASSELL FLAHARTY 2:56 A<sup>™</sup> /Medical 4c. County of Death 4a. Fecility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner Sykesville
If Under 1 Year | If Under 24 Hrs. Carroll County CONTINUUM CARE AT SYKESVILLE 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) 8. Date of Birth (Month, Day, Year) **Funeral** Days Months 1 XM 2□F Yrs Director 216**-**30-8925 Mar 19, 1934 Maryland Usual Residence of Decedent 10c. City, Town or Location 10d. Inside City Limits 10b. County permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylal Department of Heelth and Mental Hygiene I propriate if item 27 is marked other than "natural", or items 23a or 28e-f show eny injury or other traumatic event, the Madical Examination must be natified at once. 1 ☐ Yes 2 ☐ No Funeral Director Maryland | Carroll County Finksburg 10f. Zip Code 10g. Citizen of What Country? 10e. Street and Number 2630 Sunset Lane 21048 USA 12. Was Decedent Ever in U.S. Armed Forces? 14. Race - American Indian, Black, White, etc. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marital Status 1 ☑ Yes 2□No If Yes, Give Year or Dates: Korean 1 Never Married 2 Married 3 Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🙀 No Specify: White ģ 3 Widowed 4 Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Air Filter Company <u>Plant Manager</u> 18. Mother's Name (First, Middle, Maiden Surname) 17. Father's Name (First, Middle, Last) Be Charles Lassell Flaharty Virgie Edith King 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2530 Sunset Lane, Finksburg, Maryland 21048 Stephen M. Brown (Nephew) 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Green Mount Crematory 7/25/2006 Baltimore, Maryland 21. Signature Funeral Service Loanses

Martin D. Lawson 22. Name and Address of Facility Mitchell-Wiedefeld Funeral Home, Inc. Plat LITE D. Lawson 6500 York Road, Baltimore, Maryland 21212

23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,

Approximately 100 and 1 failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Cuncer **Physician** /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Physician/Medical Examiner ete has been signed by the attending physicien and page 2 should be deteched for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760 IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Dav Year 4☐Pregnant at time of death 5 Other (specify) 9 Unknown 9 Unknown 23e. Did tobacco use contribute to the cause of death? Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. ģ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 ∰nknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an this certificete has autopsy performed? 2 🗆 No 1 ☐ Yes 2 No Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Hospital: Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 1 Inpatient 2 ER/Outpatient 3 DOA 28a. Date of Injury (Month, Day Year) 28b. Time of Injury Certification: 27. Manner of Death 28d. Describe how injury occurred te Natural 5 Pending 1 ☐ Yes 2 ☐ No investigation 2 Accident 6 Could not be determined 3 ☐ Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide 16 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Riclye Ruad Westminister MAHMOUD 31. Date filed (Month, Day, Year) 32. Registrar's Signature State JUL 2 6 2006 Registrar

			ate of Maryland / Do 5,27,28a-f per	partment of ME C857 07 Pertificate of	lealth and Mental	Hygiene Reg. No.	06 23461
Physicia	ın	Decedent's Name (First, Middle, Last)			Mon		Year 8-25 AM
/Medica	al .	Audrey M. Gary 4a. Facility Name (If not institution, give stree	t and number)	4b. City, Town,	or Location of Death	9 8 <i>2</i> 4c. County	(00)
Examilie	31		nter	Rosed		Bal	timore
Funeral Director		5. Social Security Number 6. Sex 2 1 7 – 18 – 68 0 9	7. Age (In yrs. last birth 2⊈F 82 Yr	Months   Days	Hours Min. 8. Date (Mon	of Birth th, Day, Year) 9,1924	Birthplace (State or Foreign Country)     MARYLAND
and and		Usual Residence of Decedent  10a. State 10b. County	10c. City, Town	or Location			10d. Inside City Limits
Maryl -f sho	to	MD. N/A	BALT	'IMORE			1 ZVes 2 □ No
r 28a	irec	10e. Street and Number		10f. Zip Code		10g. Citizen of V	Vhat Country?
23a c	a D	414 S. EXETER ST	REET	21	202	U.S	.A.
2 should be filed within 72 hours after death with the Maryland and Mental Hygiene. and Mental Hygiene. It is marked other than "natural", or Items 23a or 28a-f show aumatic event, it is medical Examiner must be notified at	by Funeral Director	1 Never Married 2 Married 1	Vas Decedent Ever in U.S. transport to the control of the contro	<ol> <li>Was Decedent of If Yes, specify Cub</li> <li>1 ☐ Yes 2 X No</li> </ol>	Hispanic Origin? (Specify Yes pan, Mexican, Puerto Rican, et Specify:	or No- c.) 14. Rac Blac Specify	e - American Indian, ck, White, etc.
72 hours aff	edb	15. Decedent's Educatio	n 16a. D	ecedent's Usual Occu	pation	16b. Kind of Bu	WHITE usiness/Industry
permit. Pages 1 and 2 should be filed within 72 ho Department of Health and Mential Hygiene. Infinity of Health and Mential Hygiene. In marked other than "natur any injury or other traumatic event, it a Medical ODEs.	Completed	(Specify only highest grade core	npleted) (	Give kind of work done fe. DO NOT use retire WIREMAN	during most of working		NGHOUSE
e filec al Hyg othe vent,	Be C	17. Father's Name (First, Middle, Last)			18. Mother's Name (First, A	Middle, Maiden Suman	ne)
ould b Menta arked atic a	Po	JOHN ALBERT QU	INN		HAZEL BENN		RRIEDEN
d 2 should be fill the and Mental Hy? Is marked oth traumatic aven		19a. Informant's Name/Relationship (Type, F			t and Number or Rural Route		
1 and Health Health Hear tr		JOSEPH RUSS/ SON  20a, Method of Disposition		WEYMOU'I'I	H CIRCLE, BLU		C. 29910  City or Town, State
permit. Pages 1 a Department of Hee Mportant: If item Iny injury or otha		1 ☐ Burial 2XXX remation 3 ☐ Remo	val from State cemetery,	crematory or other pla	ace)		
permit. Pag Department Important: any injury c	ij	* 4 □ Donation 5 □ Other (Specify) 21. Signature of Fune User Ice Licensee	BAIVIE		ORY  6/9/06 ZEILER INC TERN AVENUE,		ORE, MARYLAND
	-	23a. Part1. Enter the disease, or complication	ons that caused the death. Do no				E, MD. 21231 Approximate
Pnysician /Medical Examiner			end Store Chro	nic obstr	ctive plmona	ry disease	Interval Between Onset and Death
ecuted and transit	Examiner	Sequentially list conditions, and any leading to introduce cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of			16/	
ificate be executed g physician and as the burial-transit	dical	d	Due to (or as a consequence of		$-\int M_{V}$	ME M EXAMINE	
The law requires that the death certificate be executed the has been signed by the attending physician and bage 2 should be detached for use as the burial-transit	Physician/Me	in the past 12 months?	f yes, outcome of pregnancy □Live birth 2 □ Fetal death 4□ Pregnant at time of death 9□ Unknown	3 ☐ Ectopic pregnand 5 ☐ Other (specify)	GENTRICATION APPROV	23d. Dai Mo	te of delivery nth Day Year
w requires that been signed b should be deta	ed by Pr	Part II. Other significant conditions contribu	iting to death but not resulting in the	he underlying cause g			nbute to the cause of death?  3 Probably 4 Unknown
hysician: The law requires this certificate has been signe I director, page 2 should be o	Completed by	V			24a	autopsy performed?	Were autopsy findings available prior to completion of cause of death?  □ Yes 2□ No
cian: ertifica ector,	Be (	25. Was case referred to medical examiner?			26. Place of Death (Check		
_ ≥ ≥ 0	P	1 Yes 2 100	I Inpatient 2 EH/Outp	atient 3 DOA	her: 4 Nursing Home 5		
ling F	lon		Ba. Date of Injury 28b. Tir (Month, Day Year) Inj	ury Wo		cribe how injury occurr	
death ctor: y the	licat	a C C C could not be		IOWII	28f. Loca	tion (Street and Numb	ygen tubing an er or Rural Route Number, <b>fe</b>
l or Attending after death. Director: Afte	Certification:	4 Homicide determined	Be. Place of Injury - At home, farm building, etc. (Specify)  at home	,,,,			,Baltimore,MD
To the Hospital or Attending Ph within 24 hours after death. To the Funeral Director: After th completely filled in by the funeral	Medical C	(Check only 2 Medical Examiner:	n: To the best of my knowledge, On the basis of examination and/ and manner stated.		ime, date and place, and due	to the cause(s) and ma	nner as stated.
Mithin Fo th	Me	29b. Signature and tine of certifier			se number	29d. Date signed	d (Month, Day, Year)
		1 VS25, 11	20)	70	051349	6/8	12006
1/2	4	30. Name and address of person who complete to the Value of the Value	201 Francia	SQUAN IN	DUTE DUS 15		W 21237
Sta Registr		31. Date filed (Month, Day, Year) JUL 2 6 2006	32. Registrar's Signature	le	•	)	

		1	For L State	State of N	Maryland		artment rtificate			and M		( )	006	23462
			Registrar  1. Decedent's Name (First, Middle, I	( act)		061	incate	, OI L	Jean		2. Date of Dea	Rag. No	000	3. Time of Death
	Physicia		MARY A		CAR	D 0 1/	= R				Month	Day	Year h 2006	1
V	/Medic		4a. Fecility Name (If not institution, g			0 100		Fown or	Location o	of Death	3009		ounty of Death	
	Examin	er	Genesis Multi					l'ows		, Dodo			Baltimo	ore
	Franci				Age (In yrs. I	ast birthday)	If Under		If Under		8. Date of Birt	h	9. Birtt	hplace (State or Foreign untry)
	Funeral Director		099-22-1212	1 □ M 2 □ XF	82	Yrs.	Months	Days	Hours	Min.	8. Date of Birt (Month, Da 7-19	–24	Col	N.C.
			Usual Residence of Decedent				1							
	nylan how		10a. State 10b. County	7.3	10c. City	Town or Lo								10d. Inside City Limits 1 XYes 2 No
	e Ma Sa-fe	5	Md. N	N A		Balti								
	or 2	Die	10e. Street and Number	n d			10f. Zip	Code 2121	12			10g. Citize	n of What Co	untry?
	within 72 hours after death with the Maryland ene. then "naturel", or Items 23a or 28a-f ehow the Modical Examit of Aust be muiffed at	by Funeral Director	1017 Woodson	12. Was Decede	et Ever in 110	6 12	Man Daged			ain? (Spe	acifu Vac or No	14	. Race - Amei	rican Indian
	ler de	in .	<ul><li>11. Marital Status</li><li>1 ▼Never Married 2 Married</li></ul>	Armed Force	s?	3.	If Yes, spec	fy Cuba	n, Mexican	, Puerto	ecify Yes or No Rican, etc.)		Black, White	
36	Irs af	by	3 Widowed 4 Divorced	If Yes, Give Year or Date	-		1□Yes 2	<b>⊠</b> No	Specify:			S	pecify:	Black
21215-0036	2 hou		15. Decedent's	Education		16a. Dece	dent's Usua kind of wor	l Occupa	ation	t of worki	na l	16b. Kind	of Business/l	Industry
215	hin 7	ple	(Specify only highest ( Elementary/Secondary (0-12)	College (1-4c	or 5+)	life.	DO NOT us	e retired,	)			01		NT N7
	filed within I Hygiene. other then ent, Ire M	Completed	llth grade			Hom	e Att	enda					te of	N.Y.
Maryland	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Department of Health and Mental Hygiene. Importants if item 271e marked other then "naturel", or Items 23a or 28a-1 ehow any injury or other treumetic event. If a Modical Examination and be notified at once.	Be	17. Father's Name (First, Middle, La James	vir	gil	Ga	rdner	-		or's Name llie	e (First, Middle,	Maiden St	<sub>umame)</sub> Alsto	n
Z	shoul nd Me mark meti	၉	19a. Informant's Name/Relationship	p (Type, Print)		19b. Mailin	ng Address	(Street a	and Numbe	er or Rura	al Route Numbe	er, City or T	own, State, Z	Zip Code)
	nd 2 :: alth ar 27 le r treu		Bernice Lee	Nieœ		1017	Woodson	n Rd.	, Balt	imore.	, Md. 2	1212		
ē,	s 1 a f Hez item othe	Create	20a. Method of Disposition		C4	lace of Dispo	osition (Nam	ne of ther place	e)		Date	20c. Loca	tion - City or	Town, State
E	Page ent nt: If ry or		1  Burial 2  Cremation 3  1  Donation 5  Other (Spe		" Kir	g Mem.	Pk.			7–26–			allstown	
Baltimore,	permit. Departrimports Imports any inj		21. Signature of Funeral Service Lie	censee	_		2. Name and			•			Md. 2L	202
_	20529		1 Dlady	, war	-		larch F				l E. Nord		•	
			23a. Part1. Enter the disease, or co shock, or heart failure. List or	omplications that caus nly one cause on each	sed the death n lin <i>e</i> .	n. Do not ent	ter the mode	e of dying	g, such as	cardiac c	or respiratory a	rrest,		Approximate Interval Between Onset and Death
4	Physician		Immediate Cause (Final disease or condition	-a. FAIL	URE	7	0 7	741	RIV	E				Monuto
	/Medical Examiner		resulting in death)		as a consequ	uence of):					1			0.00
1	- 4	<u>L</u>	Sequentially list conditions,	b. End	o ST	rAQ(	= 1	DEV	YED	3 7 16	4			monus
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<i>V</i>	be executed iician and burial-transit	Examiner	that initiated events resulting in death) Last	0.	as a consequ		, ,.				, - 6 3/2			7
760	ite be ex iysician ne burial	call		d										
68	iificati g phy as th													
Вох	death certificat e attending phy id for use as th	M/u	IF FEMALE: 23b. Was decedent pregnant	23c. If yes, outcor			⊒Ectopic pr	egnancy				23	d. Date of deli	,
	0 000	by Physician/Med	in the past 12 months? 1 ☐ Yes 2 ☐ No	4□Pregnan 9□Unknow	t at time of de		Other (sp						Month	Day Year
P.0	that the de ed by the detached	Phy	9 Unknown			ulting in the c	and orbitan a	21100 01111	on in Port I		23a Did t	obacco use	contribute to	the cause of death?
	es gu		Part II. Other significant condition	is contributing to deat	n but not rest	uting in the u	indenying ca	ause give	en in Farti	•			No 3 ☐ Pro	_
orc	w requir been si should	eted												
Vital Records,	2 5 2	Completed									24a. Was autor perfo	an osy irmad?	prior to death?	topsy findings available completion of cause of
<u>=</u>	Th ate pag										1 □ Yes	22 No		2 No
Vit		o Be	25. Was case referred to medical examiner?  1 ☐ Yes 2 ☐ No	Hospital:	atient 2 🗆	FD/0	nt 3 DO	Othe	0.00	-	n <i>(Check only c</i> me 5 ☐ Resi		TOther (Con-	
of	Phys r this	$\vdash$	27. Manner of Death	28a. Date of I (Month,		28b. Time o		8c. Injun Work		-	28d. Describe			ony)
on	iding I th. : After s funer	tlor	1 ☐Natural 5 ☐ Pending 2 ☐ Accident investiga		Day Year)	Injury	м		k? Yes 2□	No				
Division	of or Attending after death. I Director: After d in by the fune	ifica	3 Suicide 6 Could no 4 Homicide determin	286. Place UI	Injury - At ho	ome, farm, st	reet, factory	, office			28f. Location (		Number or Ru	ıral Route Number,
Ö	el or s afte of Dir	Certification:	4   Hornicide	building	, etc. (Opecii)	·/·								
	Hospitel or the hours after Funerel Dir tely filled in	edical (	(Check only 2 Medical E.	Physicien: To the be xeminer: On the basi	s of examina	wiedge, deat tion and/or ir	th occurred ivestigation.	at the tim	ne, date ar pinion, dea	nd place, ith occurr	and due to the red at the time,	cause(s) ar	nd manner as lace, and due	stated. to the cause(s)
	To the Hospitel or within 24 hours after To the Funerel Directorn completely filled in E	Medi	one) 29b. Signature and title of certifier	and manner	stated.		1.00	17				and Data	singed (Mont	h Car Vaar
	Viit To		Syp L	e.				DO	05	2 ;	0	TULL	244	10 2,045 B.A
	^		30. Name and address of person w	the completed sauce	of death /Item	23a\ (Tuno	Print)			5 /	50	5007	TEI	MAD
	2		5h CLUN MA	A Call	PT A	965	056	M	IA G	0 %	CAD	(.0	2014	B.A
	Sta	ite	31. Date filed (Month, Day, Year)	32. <b>1</b> 69	istrar's Signa	turo	Ø :							
	Regist		JUL 26	2006	istrar's Signa	St A	never	) 						
				- 1		- 8								

## Please Type or Print in Black Indelible Ink

ephen Gonski		State of Maryland / Department of Health and Mental 1- For State  Certificate of Death	al Hyg		2.0	06 2	21.6
Physicia	ın/	1. Decedent's Name (First, Middle,Last)	2.	Date of Dea	eg. No.	3. Time of D	eath
edical Exami		Stephen Gonski	Ι,	Month July 19, 2	Day Year 006	1903 hi	rs
		4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of	f Death		4c. County of	Death	
		2108 Boston Street Apt 312 Baltimore					
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs last birthday) If Under 1 Year If Under	~	8. Date of Bir	rth (MM/DD/YYYY)		
Director		076-10-4135   12 M 2 F   90 Yrs.   Months   Days   Hours	Min.	08/20	9/1915	oreign Ne Country) Yor	
		Usual Residence of Decedent			771213	101	
× any		10a. State 10b. County 10c. City, Town or Location				10d. Inside (	
Maryland 28a-f show d at once,	ō	Maryland N/A Baltimore				1 X Yes	2 No
Mary 28a-	ē	10e. Street and Number 10f. Zip Code		1	0g Citizen of What	Country?	
death with the Maryland or items 23a or 28a-f sho must be notified at once	Funeral Director	2108 Boston Street Apt 312 21231			United St	tates	
eath with the items 23a	era	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin 1 Never Married 2 Married Armed Forces? 11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin 15. If Yes, specify Cuban, Mexican, I	in? (Spec	ify Yes or No	14. Race - A White, 6	American Indian, 81	lack,
r death or ite	필	1 Yes 2 No		Jan, 515.7	VVIII.O, C		
215-0036 be filed within 72 hours after ntal Hygiene rked other than "natural"; c	b	3   Widowed   4   Divorced   If Yes, Give Year   WWII   1   Yes   2 \times No   specify:   15. Decedent's Education (Specify only highest grade completed)   16a. Decedent's Usual Occupation (Give ki	ind at			White	
2 hour	Completed	Elementary/Secondary (0-12) College (1-4 or 5+)			16b. Kind of Busin	ess/Industry	
136 Fin 7; than edical	aldı	1 Section Chief			Correspon		
d with	Son	17. Father's Name (First, Middle, Last)  18. Mother's 18.	s Name (F	irst, Middle, I	Governm Maiden Surname)	lent_	
21215-0036 uld be filed within 72 Mental Hygiene marked other than 'c event, the Medical	Be (		z .Tan	owicz			
2 P & E 2	Ţ	19a. Informant's Name/Relationship (Type, Print )  19b. Mailing Address (Street and Number)	ber or Rur	al Route Nur	mber, City or Town,	State, Zip Code)	
		George Sluti - Nephew 10 East End Avenue	e On	eonta,	New York	13820	
ore, MEss 1 and 2 soft Health as If item 27 ter traum.		20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, crematory or other place)	Г	)ate	20c Location - Cu	ty or Town State	
Baltimore, permit. Pages I a Department of He Important: If ite		1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other Specify:  Crematory or other place)  Garrison Forest Maryla  Veteran Cemetery	and <sub>07</sub>	/28/06	Owings N	Mille Ma	ryl and
alti mit. partm ports jury o		22. Name and Address of Facility				HILLS, CIA	I y I CIII
<b>a</b> 5 2 3 1 1 1 1 1 1 1 1		David J. Weber 401 S. Chester	Stre	et Ral	timore N	farvland	21231
Physician		23a. Part I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as car failure. List only one pause on each line.	rdiac or re	spiratory arr	est, shock, or heart	Approximat Between C	te Interval
/Medical Examiner		Immediate Cause (Final disease a Hyperthermia complicating Hypertensive Atherosclerotic	Cardio	vascular [	Disease	Dea	
		or condition resulting in death)  Due to (or as a consequence of):					
	er	Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
	Examiner	cause. Enter Underlying Cause (Disease or injury that initiated					
cuted and transit	Exa	events resulting in death) Last Due to (or as a consequence of):					
execu an and	<b>l</b> edical	UNPENDED AMENDED					
60, ate be exe hysician e burial -	Ned	IF FEMALE: 23c. If yes, outcome of pregnancy			23d. Date of de	livery	
Sox 68760, leath certificate be attending physicifor use as the burn	sician/N	23b. Was decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic	pregnancy	y	Month		Year
Box (e death ce the attence ed for use	sici	1 Yes 2 No 9 Unknown Pregnant at time of death 5 Other (Specify)					
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of V g Phy ier thi	. To	27 Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work2			how injury occurred	orier, scene	
on ath. he fur	tion	1 Natural 5 Pending FOWND: 1 Yes 2 V	NO I	ibject exp nperature	osed to high er	vironmental	
Division tal or Attendi rs after death. al Director: A	Certification:	2 Accident Investigation Jul 19, 2006 1845 hrs  3 Suicide 6 Could not be 28e. Place of Injury - At home, farm, street, factory, office building, etc.		f. Location (S	Street and Number of	or Rural Route Nun	nber, City
Divinal o	erti	Suicide 6 Could not be determined (Specify) Multi-Family Apt.	21	or Town, S 08 Bostor	State) n Street Apt 31	2, Baltimore, N	MD
Hosp 24 ho Fune rtely f		29a. Certifier 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and plac					
Division of Vital F To the Hospital or Attending Physician: within 24 hours after death. To the Funeral Director: After this certificompletely filled in by the funeral director.	Medical	one) 2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurrence and manner stated.	urred at th	ie time, date	and place, and due	to the cause(s)	
- > - >	ž				29d. Date signed	(Month, Day, Year)	)
1		O.C.M.E.			July 20, 2006		
140		30. Name and address of person who completed cause of death (Item 23a)	04001		·		
		Ana Rubio MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 2	21201				
St Regist	ate						

State of Maryland / Department of Health and Mental Hygiene For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** July 24, Year 2006 Carlyn D. Gray 12:00 PM /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death Examiner 4b. City, Town, or Location of Death Stella Maris Hospice Timonium Baltimore 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Yea NOV. 19, 1 Birthplace (State or Foreign Country) **Funeral** Months Days Hours 1 M 2 XF Director Yrs. 219-12-5534 81 1924 Maryland Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits in then "natural", or items 23s or 28e-fehow the Medical Example or must be notified at 1 Yes 2 XNo Md. Baltimore Towson Direct 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 10 Choate Court filed within 72 hours after death Hygiene. Apt. C 21204 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian. Black, White, etc. 1 Yes 2 No If Yes. Give 1 Never Married 2 Married 1 ☐ Yes 2 X No Specify: f Yes, Give Year or Dates: þ 3 X Widowed 4 ☐ Divorced White Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) 12 Administrator Banking 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) John Daue Carrie Seigle permit. Pages 1 and 2 st Department of Health and Importent; if item 27 is ma any injury or other traumance. 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Mr. Ray Daue/Nephew 2221 Wonderview Road Timonium, Maryland 21093 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) Hilltop Service Corp. 7/25/06 Towson, Maryland 21. Signature of Funeral Service Licen 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that cause the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Immediate Cause (Final disease or condition resulting in death) **Physician** a END STAGE RENAL DISEASE /Medical Due to (or as a consequence of): Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examiner physicien and s the burial-transit Due to (or as a consequence of): Physician/Medical attending p IF FEMALE: use 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Day Year 4☐ Pregnant at time of death 5 Other (specify) 9 Unknown cate has been signed page 2 should be det Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 X Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? cartificate has autopsy performed? 1 Yes 2 No 1 ☐ Yes 2 ☐ No director 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 NOther (Specify) HOSPICE 1 ☐ Yes 2 No ၉ this 27. Manner of Death 28a. Date of Injury (Month, Day Year) Certification: 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred After the Hospital or Attending Injury 1 X Natural 5 Pending 1 □ Yes 2 □ No investigation Director: 2 Accident 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Homicide within 24 hours a To the Funeral C 1X Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. cal 29a. Certifier (Check only 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 114372 10 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) DR. TARIQ MAHMOOD 2300 DULANEY VALLEY RD. TIMONIUM, MD 21093 31. Date filed (Month, Day, Year)
JUL 2 6 2006 32. Resistrar's Signature State Registrar

DHMH 17 Rev 1/2001

21215-0036

Maryland

Baltimore,

Vital Records, P.O. Box 68760

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Division

12:00

State of Maryland / Department of Health and Mental Hygiene Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month 10P M GRAY WILLIAM 07 82 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death Examiner 4c. County of Death Genesis Brightwood Conter BALTIMORE Co BALTIMORE 8. Date of Birth (Month, Day, Year) DAC. 8, 1921 If Under 1 Year If Under 24 Hrs. 6. Sex 1 M 2 F 5. Social Security Number 7. Age (In yrs. last birthday) 9. Birthplace (State or Foreign **Funeral** Months Days Min. Hours 215-12-7161 84 Yrs. Maryland Director Usual Residence of Decedent with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits 28a-fahow traumatic svant, the Medical Examiner must be notified at 1 ☐ Yes 2 No Director Baltimore Towson 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? permit. Pages 1 and 2 should be filled within 72 hours after death with Department of Health and Mental Hygiene. Important: If item 27 is marked other than """ any highy or other traumation. ō Items 23a 10 Choate Court Apt. C 21204 USA Completed by Funeral 12. Was Decedent Ever in U.S. Armed Forces? Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. 1 X Yes 2 □ No If Yes, Give Year or Dates: 1 Never Married 2X Marned 1 ☐ Yes 2X No Specify 3 Widowed 4 Divorced WWII Specify. Whi te 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) College (1-4or 5+) Sales Representative Finance 4 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be John Gray 2 Mary Downs 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2221 Wonderview Road Timonium, Maryland 21093 Mr. Ray Daue/Nephew 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) Date 20c. Location - City or Town, State 1XXBurial 2 Cremation 3 Removal from State 4 □ Donation 5 □ Other (Specify) Dulaney Valley Mem. Grd. 7/27/06 Timonium, Maryland 21. Signature of Funeral Service Licensee 22. Name and Address of Facility Ruck Towson Funeral Home, Inc. 1050 York Road Towson, Maryland 21204 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final PROSTATE CANCER with **Physician** disease or condition resulting in death) 540 /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, it any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) Examine or Attending Physician: The law requires that the death certificate be executed use as the burial-transit Due to (or as a consequence of) P.O. Box 68760. attending physicien for use as the buria Completed by Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy
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2. Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certitier Medical the 29b. Signature and title of certifier 29c. License numbe 29d. Date signed (Month, Day, Year) D 2564 9006 of death (Item 23a) (Type, Print) Dendoll R. Faulkner MD 16565 N. Charles St Sueta 209 31. Date filed (Month, Day, Year) 32. Registrar's Signature State Registrar JUL 2 6 2006

ORIGINAL

		1-	For State Registrar		State of M	Maryland / Dep	partment of F e <i>rtificate of</i>	dealth and M <i>Death</i>		giene Reg. No.	2006	23466
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/Medi	ical	46	Martha		. Gri		4L Ch Town	al anating of Dooth			2006 Year	7:55 a A
Exami	ner	4a.	Facility Name (If not Stella	_	e street and number	")		or Location of Death		40.0	Baltimo	re
uneral irector		2	Social Security Number 16-46-1939	)	Gex 1 □ M 2 🔀 F	nge (In yrs. last birthda 54 Yrs.	y) If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Bir NOV 2,	<sup>th</sup> . 1 <b>3</b> 51	9. Birthr Mary	lace (State or Foreig
-I show	tor	_	ual Residence of Dec a. State 10b	o. County		10c. City, Town or Baltim					1	0d. Inside City Limit:
ast be not	ai Direc	10e	Street and Number	Liam St	reet		10f. Zip Code 21 2	30		_	en of What Cour	ntry?
importent: If tiem 2.7 is marked other then "naturel; or tiems 23e or 28e-1 enow eny injury or other treumatic event, the Medical Examinar must be notified at opice.	by Funeral Director		Marital Status 1   Never Married 3   Widowed 4   □		12. Was Deceden Armed Forces 1  Yes 2  If Yes, Give Year or Dates	] No	3. Was Decedent of H If Yes, specify Cub  1 ☐ Yes 2 No  2 No		ecify Yes or No Rican, etc.)		4. Race - Americ Black, White, Specify: 山山i	etc.
e Medical	Completed	E			ducation ade completed) College (1-4or	(Gir	cedent's Usual Occup ve kind of work done DO NOT use retire	pation during most of work d)	ing		of Business/In	dustry
c event, #	To Be Co	17.	Father's Name (First)	, Middle, Last	Grill			18. Mother's Name				m
r treumati	F	9	a. Informant's Name/I Philip A.				iling Address (Street					Code) 21210
ry or other		20a	Method of Disposition  1	emation 3 [	Removal from State	cometon, c	position (Name of rematory or other place Park	ce) i	Date 5/06		cation - City or To L <b>timore</b> ,	
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an cal		Imi	a. Pan1. Enter the dis shock, or heart fail mediate Cause (Final lease or condition sulting in death)	ure. List only	oplications that cause one cause on each	ed the death. Do not e	1050 York inter the mode of dyin	Rd., Tows	son, MD	212		Approximate Interval Between Onset and Death
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DHMH 17 Rev 1/2001

State Registrar

			- Statemend Item #11 Registrar	State of Marylan Per Inf G858	8/02/ Cer	tificate of L	ealth and Death	Mental Hygi	ene, 006	23467
	Dhusisi		1. Decedent's Name (First, Middle, Last	)	-	_		2. Date of Death Month	Day Year	3. Time of Death
	Physicia /Medic		Joseph Gordon Ha	11				July	20 2000	
	Examin		4a. Fecility Name (If not institution, give	street and number)		4b. City, Town, or	Location of Deat	h	4c. County of De	ath
			Union Memorial H			Baltim			N/A	
	Funeral		5. Social Security Number 6. Se	XM 2□F	ast birthday) Yrs.	If Under 1 Year Months Days	If Under 24 Hrs Hours Min.	(Month, Day,	Year) (	irthplace (State or Foreign Country)
	Director		217–20–2681 Usual Residence of Decedent	79	113.			05/23/1	927 Ma	ryland
	land		10a. State 10b. County	10c. City	, Town or Lo	cation				10d. Inside City Limits
	Mary feh	ō	MD Baltim	ore	Cato	nsville				1 ☐ Yes 2 📉 No
	1 the	Director	10e. Street and Number			10f. Zip Code		10	g. Citizen of What (	Country?
	3a o		601 Maiden Choice	P Tane Ant. #8		21:	228		United	States
	death ms 2	Jere	11. Marital Status	12. Was Decedent Ever in U.	S. 13. V	Vas Decedent of Hi	spanic Origin? (S	Specify Yes or No-	14. Race - An	nerican Indian,
9	after or ite	by Funerai		Armed Forces? 1 ⊠Yes 2 ☐ No If Yes, Give		Yes, specify Cuba □ Yes 2  No	n, mexican, Puer Specify:	to Hican, etc.)	Black, Wh	
8	hours after death with the Maryland tural', or Itema 23a or 28e-f ehow al Examinar must be notified at		3 ☐ Widowed 4 ☐ Divorced	Year or Dates:		165 220140	эрвспу.		Specify: W	hite
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Ž	d 2 should be filed within 72 hours after death with the Marylan th and Mentla Hygliene. If a marked other then "natural", or lieme 23a or 28e-f show traumatic event. The Medical Examinar must be notified at	2	Howell Gordon Ha.  19a. Informant's Name/Relationship (T)		19h Mailin	n Address (Street a		Marie Hu		Zin Code)
Maryland	id 2 sho ith and 27 is mu traum		No. 1	6:51 N. 75						m in Spinson
d)	s 1 and if Health item 27 other to		Marie McWilliams 20a. Method of Disposition	20b. P	ace of Dispos	sition (Name of		tonsville Date 2	Oc. Location - City of	
Baltimore,	permit. Peges 1 Deportment of H Important: If Ite any njury or ot once		1 ☑ Burial 2 ☐ Cremation 3 ☐ 4 ☐ Donation 5 ☐ Other (Specify	Removal from State		natory or other plac lge Cemete	· 1	24/2006 1	Raltimoro	, Maryland
≣.	P. Dries		21. Signature of Funeral Service Libers	12200	22	. Name and Addres	s of Facility	bbard Fund		, Maryland
ã	Per Per Per Per Per Per Per Per Per Per		mind A	aur	7	107 53116	HU Na Aron	bbard Fune	eral Home	, inc. yland 21229
			23a. Part1. Enter the disease, or comp	lications that caused the death	. Do not ente	er the mode of dying	g, such as cardia	c or respiratory arres	itore, Mar	Approximate
	Physician		shock, or heart failure. List only o Immediate Cause (Final	11 1						Interval Between Onset and Death
и	/Medical		disease or condition resulting in death)	a. Nypertens						30 years
	Examiner		Consistent the second second	Coronary	Arter	1 Disea	50			30 YELLS
	n =	ner	if any, leading to immediate cause. Enter Underlying	Due to (or as a con or of occaved)	ience of):		1			1 week
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Ő,	cate be executed physicien and the burial-transit		resulting in death) cast	Due to or as a consequ	ience of):					
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o.	0 00	ysic	1 ☐ Yes 2 ☐ No 9 ☐ Unknown	9□ Unknown	sain J_	Other (specify)				
<u>α</u>	that the de ted by the a detached f		Part II. Other significant conditions co	ntributing to death but not resu	Ilting in the ur	nderlying cause give	en in Part I.	23e. Did toba	acco use contribute	to the cause of death?
Vital Records,	The law requires that the ate hes been signed by th page 2 should be detache	d by						1 ☐ Yes	2 □ No 3 🗹	Probably 4 Unknown
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<u>&gt;</u>	Physician: this certific ral director,	To B	examiner? 1 \( \text{Yes} \) 2 \( \text{No} \)	Hospital:	ER/Outpatien	t 3 DOA Othe	20	dome 5 ☐ Residen		ecify)
J Of			27. Manner of Death	28a. Date of Injury (Month, Day Year)	28b. Time of Injury	28c. Injury Work		28d. Describe how		,
Ö	o at a	aţie	1 ☑Natural 5 ☐ Pending 2 ☐ Accident investigation	(1101111) 02) 102)	,		Yes 2 □ No			
Division	or Attending ifter death. Director: Afte in by the fune	Certification;	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of Injury - At ho building, etc. (Specify	me, farm, stre	et, factory, office		28f. Location (Stre City or Town,	et and Number or I State)	Rural Route Number,
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	To the Hospital or Atte within 24 hours after de To the Funeral Direct completely filled in by ti	Med	29b. Signature and title of certifier	and manner stated.		29c. License	number	יסה	d. Date signed /Mo:	nth Day Year
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	D'Y		30. Name and address of person who constituted the control of the	CKINSTVV MI	) / //	in No.	narial	Arxnita1	MN	
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	Registr		JUL 2 6 2001	Olever St	ESTE	464				

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. State of Maryland / Department of Health and Mental Hygiene Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Day Month Year **Physician** July 24, Norma Louise Hess 2006 12:40P M /Medical 4c. County of Death 4a. Facility Name (If not institution, give street and number) 4b. City. Town, or Location of Death **Examiner** Charlestown Care Center Catonsville Baltimore If Under 1 Year If Under 24 Hrs.
Months Days Hours Min. 5. Social Security Number 8. Date of Birth (Month, Day, Year) June 22, 1 Birthplace (State or Foreign Country) 7. Age (In yrs. last birthday) **Funeral** 1 □ M 2 1 1 F 167-22-9232 Yrs. 77 Director Pennsylvania Usual Residence of Decedent filed within 72 hours after death with the Maryland 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits other than "natural", or items 23a or 28a-f ahov rent, Ite Medical Experience by notified at MD Baltimore Catonsville 1 ☐ Yes 2 ☑ No Director 10e Street and Number 10f. Zip Code 10g. Citizen of What Country? 709 Maiden Choice Lane S106 21228 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 11 Marital Status 1 □Yes 21∑No If Yes, Give Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 Specify: White 1 ☐ Yes 2 No þ 3XXWidowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry Elementary/Secondary (0-12) 1 2 College (1-4or 5+) Homemaker Own Home permit. Pages 1 and 2 should be file Department of Health and Mental Hy Important: If Item 27 is marked othe any injury or other traumatic event, once. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) Be Earl Knost Doris Curtis 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Karin A. Hickman - Daughter 231 Ridgeway Road; Catonsville, MD 21228 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 

Burial 2 □ Cremation 3 □ Removal from State Crest Lawn Mem. Garden7-27-2006 Marriottsville, Maryland

22. Name and Address of Facility Sterling-Ashton-Schwab-Witzke
Funeral Home of Catonsville, Inc.
1630 Edmondson Avenue; Catonsville, MD 21228 4 ☐ Donation 5 ☐ Other (Specify) 21. Signature of Funeral Service Licenses 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Physician 201 (RIL /Medical Due to (or as a consequence of) Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examine To the Hospital or Attending Physician: The law requires that the death certificate be executed physician and s the burial-transit Due to (or as a consequence of): Box 68760, by Physician/Medical signed by the attending the detached for use as IF FEMALE: 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month Day Year 4 Pregnant at time of death 5 ☐ Other (specify) Division of Vital Records, P.O. 9 Unknown 9 Unknow Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy performed? certificate 1 Yes 2 No 1 Tyes 2□ No Director: After this certific I in by the funeral director, 25. Was case referred to medical examiner? Certification: To Be 26. Place of Death (Check only one) Other: 42 Nursing Home 5 Residence 6 Other (Specify) Hospital: 1 ☐ Yes 2 ☐ No 1 ☐ Inpatient 2 ☐ ER/Outpatient 3 ☐ DOA 28a. Date of Injury (Month, Day Year) 28b. Time of 27. Manner of Death 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural
2 Accident 5 Pending investigation 1 ☐ Yes 2 ☐ No death. 6 ☐ Could not be 3 Suicide 28f. Location (Street and Number or Rural Route Number, City or Town, State) Place of Injury - At home, farm, street, factory, office building, etc. (Specify) within 24 hours after of To the Funeral Direct Completely filled in by 4 | Homicide Certifying Physicien: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical 29d. Date signed (Month, Day, Year) 29b. Signature and title of certifier 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Moliden -alles 31. Date filed (Month, Day, Year) 3 Registrar's Signature

State Registrar

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death Day **Physician** KONALD HADDAWAY JULY 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner 8608 FOWIER PARKUILLE BALTIMERE If Under 1 Year | If Under 24 Hrs. Months | Days | Hours | Min 5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 8. Date of Birth (Month, Day, Year) JULY 24, 1948 Birthplace (State or Foreign Country) **Funeral** Days 220-52-4067 Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits rthan "natural", or itama 23a or 28a-f ahov tra Madical Examinar must be notified at Director PARKUIlle 1 Yes 2 No MD BALTIMORE 10e, Street and Number 10g. Citizen of Whal Country? 21234 U.S.A AVE 8608 Funeral 12. Was Decedent Ever in U.S. Armed Forces?

1 Yes 2 10 Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. filed within 72 hours after Hygiene. 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 ☐ No Specify: If Yes, Give Year or Dates: Specify: Š WhiTe 3 Widowed 4 Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) other then BAlto. COUNTY iath officer OLICE NIA Pages 1 and 2 should be filed v tment of Heelth and Mental Hygie tant: If Itam 27 is marked other t jury or other traumatic avant. 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname) Be ROBERT HADDAVAY MARY Miller ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) AUC. BAlto. MD HADDAWAY 8608 Fowler LINDA 21234 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition Date 20c. Location - City or Town, State 1 Burial 2 □ Cremation 3 □ Removal from State Important: If any Injury or once. BeLAIR BELAIR MA 4 ☐ Donation 5 ☐ Other (Specify) cemetery 106 22. Name and Address of Facility
PAUL STELLA FULLERAL HOME, PA
7527 HATFORD RD. BAITO. MD 21234 21. Signature of Funeral Service Licenses 23a. Parn. Enter the disease, or complications that caused the death. Do not shock, or heart failure. List only one cause on each line. enter the mode of dying, such as cardiac or respiratory arrest, Approximate Interval Between Onset and Death Deveradorine Immediate Cause (Final **Physician** disease or condition resulting in death) /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of): Examiner been signed by the attending physicien and should be detached for use as the burial-transit Due to (or as a consequence of): Division of Vital Records, P.O. Box 68760, Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 Live birth 2 Fetal death 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy in the past 12 months? Month Dav Year 4☐Pregnant at time of death 5 Other (specify) ☐Yes 2☐No 9 Unknown 9 Unknown Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did lobacco use contribute to the cause of death? þ Completed 1 ☐ Yes 2 ☐ No 3 Probably 4 Unknown 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death?

1 ☐ Yes 2 ☐ No this certificate hes al director, page 2 autopsy 2 No 1 Yes Be 25. Was case referred to medicat examiner? 26. Place of Death (Check only one 1 Yes 2 No Hospital: 1 ☐ Inpatient Other: 4 \sum Nursing Home 2 5 ☐ Residence 6 ☐ Other (Specify) 2 ER/Outpatient 3 DOA the funeral 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of Injury 28d. Describe how injury occurred 28c. Injury at Work? Certification: After 1 Invitural 5 Pending investigation 1 ☐ Yes 2 ☐ No 2 Accident Diractor: 6 Could not be determined 3 Suicide in by t Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 Thomicide within 24 hours t Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier 29b. Signature 29c. License number D0030149 ted cause of death (Item 23a) (Type, Print) 31. Date filed (Month, Day, Year) State 6 2006 Registrar

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### Please Type or Print in Black Indelible Ink

oseph Kyle Harris	State of Maryland / Department of Health and Mental Hygiene  1- For State Registrar  Certificate of Death Reg. No. 2 () () ()	2347
Physician/ fledical Examine	1. Decedent's Name (First, Middle,Last)  2. Date of Death  3. Ti	ime of Death 319 hrs
	4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  4c. County of Death	
Funeral	5. Social Security Number 6. Sex 7. Age (In yrs last birthday) If Under 1 Year If Under 24Hrs. 8. Date of Birth(MM/DD/YYYY) 9. Birthplac	ce (State or
Director		Maryland
any		Inside City Limits
yland t-f show once.	Maryland Anne Arundel Baltimore 1 106. Street and Number 1 106. Street and Number 1 106. Zip Code 1 100. Citizen of What Country?	Yes 2 X No
MD 21215-0036 2 should be filed within 72 hours after death with the Maryland h and Mental Hygiene 27 is marked other than "natural", or items 23a or 28a-f show matic event, the Medical Examiner must be notified at once.  To Be Completed by Funeral Director		
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21215-0036 und be filed within 7 Mental Hygiene marked other than e event, the Medica	Stephen Joseph Harris Barbara Jean Robertson	
imore, MD 21215-0036 Pages I and 2 should be filed within 72 ment of Health and Mental Hygiene lant: If item 27 is marked other than or other traumartic event, the Medical To Be Comple	19a. Informant's Name/Relationship (Type, Print) Stephen Harris / father  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip (423 W. 5th Avenue Baltimore, Maryland)	·
re, rand Fleah	20a. Method of Disposition  20b. Place of Disposition (Name of cemetery, 1 X Burial 2 Cremation 3 Removal from State Crematory or other place)  20c. Location - City or Town	ı, State
Baltimo pernit Page: Department o Important: injury or oth	4 Dynalon 5 Other Specify.  MD State Veteran Cem. 7/26/2006 Crownsville,  21. Sphere of Funeral Service Licensee  22. Name and Address of Facility Gonce Funeral Service, Funera	Maryland
	HUUI Kitchie Highway Baltimore, Maryland	1 21225
Physician /Medical		proximate Interval etween Onset and Death
Examiner	or condition resulting in death)  Due to (or as a consequence of):  Right ventricular dilatation and hypertrophy	
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B760, ifficate being physicials the buri	item#23a-b.PIT.27, perMF.g860, 10/18/06 TT  FFEMALE: 23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy 1 Live birth 2 Fetal death 3 Ectopic pregnancy Month Day	Year
the death certific, by the attending p ched for use as the Physician/I	past 12 months?  4 Pregnant at time of death 5 Other (Specify) 9 Unknown	7001
Division of Vital Records, P.O. Box 68760, the Bospital or Attending Physician: The law requires that the death certificate be executed him 24 hours after death.  the Funeral Director: After this certificate has been signed by the attending physician and applietly filled in by the funeral director, page 2 should be detached for use as the burial - transitical Certification: To Be Completed by Physician/Medical E.		
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Records, The law require fricate has been signage 2 should be	autopsy prior to comple performed? death?  1 ✓ Yes 2 No 1 ✓ Yes	etion of cause of
tal Rection: The certificate ector, page	25. Was case referred to medical 26. Place of Death (Check only one)  Hospital Control City Control Co	
Division of Vital Records, ital or Attending Physician: The law requir is after death.  al Director: After this certificate has been seen is led in by the funeral director, page 2 should be refification: To Be Completed.	27. Manner of Death 28a Date of Injury 28b Time of Injury 28c Injury at Work? 28d Describe how up uny occurred	
Sion Attendii death. ector: A by the fu	1 XX Natural 5 Pending 1 Yes 2 No Investigation	
Division c spital or Attending tours after death. Intra Director: Aft filled in by the fund Certification:	3 Suicide 6 Could not be determined 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28e. Place of Injury - At home, farm, street, factory, office building, etc. or Town, State)	ute Number, City
Division  To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the Healical Certification	1298 Certifier	se(s)
To the Ist within 24 Completed	and manner stated  29c. License number  29d. Date signed (Month, Date signed)	
4.4	O.C.M.E. July 22, 2006	
lab.	30. Name and address of person who completed cause of death (Item 23a)  Laron Locke MD. Assistant Medical Examiner 111 Penn Street, Baltimore, MD 21201	
Stat Registra		
DhMh Rev 1:200	300 h	

				1 - For State Registrar	State of Ma		epartmer Certifica				ene <sub>2</sub> 00	6 23472
		Physici /Medi		Decedent's Name (First, Middle, Last)     Clarence Ilge						2. Date of Death Month	Pay Ye	3. Time of Death
		Examir		4a. Facility Name (If not institution, give		<u></u>	4b. City	Town, or Lo	ocation of Death		4c. County of D	eath
	-	Funeral	۳	5. Social Security Number 6. Sec	7. Age	(In yrs. last birth			[ Under 24 Hrs.	8. Date of Birth	Mart 9.	Birthplace (State or Foreign
		Director		216-56-6813 1½	]M 2□F	71 Y	rs. Months	Days	Hours Min.	8. Date of Birth (Month, Day, Y Jan 18, 1	1935	Birthplace (State or Foreign Country) unk
		yland		10a, State 10b. County		10c. City, Town	or Location				<del></del>	10d. Inside City Limits
		the Marylar 28a-1 ehow	ector	MD Harfor	d	Be1	Air		·			1 ☐ Yes 2√☐ No
		14 mith 17 mit	Ē	10e. Street and Number E. MacPhail Road			10f. Zi	Code	210		J. Citizen of What U	Country?
		rs after death with the Maryla I, or Iteme 23s or 28s-1 ehov	Funera Pirector	11. Marital Status	12. Was Decedent E Armed Forces? 1 Yes 20 N	Ever in U.S.	13. Was Dece If Yes, spe	dent of Hisp cify Cuban,	anic Origin? (Spe Mexican, Puerto	ecify Yes or No- Rican, etc.)	14. Race - A Black, W	merican Indian,
	980	urs afte	ě	1 Never Married 2 Married 3 Widowed 4 Divorced	1 ☐ Yes 24∑ N If Yes, Give Year or Dates:	40	1 🗆 Yes		Specify:		Specify: T	
	21215-0036	be filed within 72 hours after death with the Maryland tal Hygiene. d other than "naturel", or fleme 23a or 28a-1 show event, the Markleal Examinar must be notified at	Completed	15. Decedent's Edu (Specify only highest grade	cation completed)	(	Decedent's Usu Give kind of wo	rk done dur	on ing most of worki	unk 16	b. Kind of Busine	ss/Industry unk
	212	d withir giene. r than	ото	Elementary/Secondary (0-12) unk uni	College (1-4or 5	+)	life. DO NOT u	se retired)				
( )		ges 1 and 2 should be filed within to the Health and Mental Hygiene. If I tem 27 is marked other than or other traumatic event, ILA Me	Be	17. Father's Name (First, Middle, Last)			un	"		(First, Middle, Ma		
Ž	aryla	should ind Men i marke umatic	2	19a. Informant's Name/Relationship (Ty)	oe, Print)	196. /	Mailing Address			lgenfritz  / Route Number, C		a Zin Codel
14	, Me	and 2 ealth a n 27 is		George Ilgenfri	z/cousin	210	05 Harv	ey Lai		ngton, MI		, zp 3333)
H	Baltimore, Maryland	Pages 1 ent of H nt: If Itee ry or oth		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐ R 4 ☐ Donation 5 ☐ Other (Specify)	emoval from State	20b. Place of D cemetery,	Disposition (National Communication (National Communication)	me of other place)		ate 20	c. Location - City	or Town, State
5	Balti	permit. Pages 1 and. Department of Health Importent: if Item 27 any Injury or other tr		21. Si hab to of Euneral Service license	ne / /	ector	State Baltim	d Address of Anaton	of Facility ny Board ID 21201	655 W. B	Baltimore	e Street
				23a. Part). Enter the disease, or complishock, or heart failure. List only or	cations that caused e cause on each lin	the death. Do no						Approximate Interval Between
		Physician /Medical		Immediate Cause (Final disease or condition resulting in death)		etast	ati	, C	alm	Cano	cer	Onset and Death
_		Examiner		Sequentially list conditions	Due to (of as a	a consequence of	):					
		nsit	Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence of	):					
	o,	be executed sicien and burial-transit		that initiated events resulting in death) Last	Due to (or as a	a consequence of	):					
	68760,	ifficate b g physic as the bi	edical									
1	Box (	eath cer attendin for use	Physician/Me	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No	3c. If yes, outcome of 1 Live birth 4 Pregnant at	2 🗌 Fetal death	3 ☐Ectopic pi				23d. Date of o	delivery Day Year
V	P.O.	that the d ed by the detached	Phys	9 🗆 Unknown	9□ Unknown							
与	Records,	requires that been signed should be del	ρ	Part II. Other significant conditions con	tributing to death bu	it not resulting in the	he underlying o	ause given i	n Part I.			to the cause of death?  Probably 4 □Unknown
出	Reco	The law resete hes be	Completed							24a. Was an autopsy performed	prior t	autopsy findings available o completion of cadse of
	Vital		0	25. Was case referred to predical				26	6 Place of Preath	(Check only one)		
-	of V	Physicien: this certifice ral director, i	ToB	T Tes	ospital:			Other:	4D Nursing Hon	ne 5 ☐ Residenc	e 6 □Other (S <sub>i</sub>	pecify)
1 (		ding After fune	tlon:	27. Manner of Death  1. Natural 5 □ Pending 2 □ Accident investigation	28a. Date of Injun (Month, Day	y 28b. Tin Year) Inju	ne of 2	8c. Injury at Work? 1 ☐ Yes	2 □ No	8d. Describe how i	injury occurred	
	Division	I or Attendi after death. Director: A d in by the fu	Certification:	3 Suicide 6 Could not be determined	28e. Place of Inju building, etc.	ry - At home, farm . (Specify)	, street, factory			8f. Location (Stree City or Town, S	t and Number or State)	Rural Route Number,
		To the Hospital or Att within 24 hours after de To the Funerel Direct completely filled in by t	edical C	29a. Certifier Certifying Physical (Check only one)	ician: To the best o er: On the basis of and manner stat	examination and/	death occurred or investigation	at the time, in my opini	date and place, a on, death occurre	nd due to the caus od at the time, date	e(s) and manner and place, and d	as stated. ue to the cause(s)
		To the within 2 To the comple	ž	29b. Signature and title of certifier	100	10	290	. License nu	umber	29d.	Date signed (Mo	nth, Day, Year)
				30. Name and address of person who co	nul III	ath (Ithm 22a) /7	M)	1	11958	3 1	ulyi	1,2006
	_	-1-		8 Law Str	ret,	Shero	lear	, Ma	vylan	1 21	001	
		Sta Registr		31. Date filed (Month, Day, Year)	Se. R. jistra	r's Signature	melle	J - 0555	/	00 == 1 = 30		

			1 - For State Registrar			partment of Fertificate of		Re	g. No. 0 0 f	5 23473
1	Physici /Medic		1. Decedent's Name (First, Middle, Last Albert	5.	John	son		2. Date of Death Month	_	3. Time of Death
	Examin		4a, Facility Name (If not institution, give Howard County		Hospital		nbia		4c. County of I	Death
	Funeral		5. Social Security Number 6. Se		(In yrs. last birthda		If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day, Feb. 12,	9	Birthplace (State or Foreign Country)
	Director		Usuat Residence of Decedent		00			reb. 12,	1918   1	New York
	death with the Maryland ims 23a or 28a-f show rmust be notified at	ō	10a. State 10b. County  Maryland Howard		10c. City, Town or Col	umbia				10d. tnside City Limits 1 ☐ Yes 2 ☑ No
	r 28a-	Directo	10e. Street and Number	1		10f. Zip Code		10	g. Citizen of Wha	It Country?
	ath wit	ralD	7110 Minstrel Way			210			U.S.A	
326	be filed within 72 hours after death with the Marylan lal Hygiene. d other than "natural", or items 23a or 28a-f show event. I'm Medical Examiner must be notified at	by Funeral	11. Marital Status  1 □ Never Married 2 □ Married  3 ☑ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ☐ Yes 2 ☑ N If Yes, Give Year or Dates:		. Was Decedent of H If Yes, specify Cuba 1 ☐ Yes 2 ☑ No	lispanic Origin? (Sp an, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		American Indian, White, etc. White
5-0036	72 hou		15. Decedent's Edu (Specify only highest grad	ication le completed)	16a. Dec	edent's Usual Occup	ation during most of work	ing 10	6b. Kind of Busin	
2121	filed within Hygiene. sther than "	Completed	Elementary/Secondary (0-12)	Cotlege (1-4or 5-	+) life	. <i>DO NOT</i> use retired alurgist	1)		Stee	<u>.</u> 1
	be filed tal Hyg d other	Be	17. Father's Name (First, Middle, Last)	_				e (First, Middle, Ma		
Maryland		ဥ	Sidney L. Johnso  19a. Informant's Name/Relationship (T)		19b. Ma	iling Address (Street	Laura S		City or Town Sta	te Zin Code)
	nd 2 lith a 27 is r trau			Son)		Severnsid		Severna		
ore	Pages 1 and the point of Head ont: If item any or other		20a. Method of Disposition 1 □ Burial 2 ☑ Cremation 3 □ F	Removal from State	20b. Place of Dis	position (Name of ematory or other place	(9:	1	0c. Location - City	
altimore,			<ul><li>4 □ Donation 5 □ Other (Specify)</li><li>21. Signature of Funeral Service Licens</li></ul>			rematory 22. Name and Addre	ss of Facility	149000 C	atonsvil	le, Maryland
ñ	permit. Departr importa any inj		1/hhb//	4		22 Name and Addre Vitzke Fun 5555 Twin	Knolls Ro	oad Colu	mbia, Ma	ryland 21045
į	Physician	N 16	23a. Part1. Enter the disease, or comp shock, or heart failure. List only o tmmediate Cause (Finat disease or condition	ications that caused ne cause on each line a	the death. Do not e e. <b>Ferial</b>	nter the mode of dyin		or respiratory arres	st,	Approximate Interval Between Onset and Death
	/Medical Examiner		resulting in death)	Due to (or as a	consequence of):	1				7 000 93
	<u> </u>	ner	Sequentially list conditions, if any, leading to immediate cases (Disease or injury	Due to (or as a	consequence of):					
	xecuter and	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	o. Due to (or as a	consequence of);	_				
98/60	ficate be executed physician and is the burial-transit	edical E		d						
_			IF FEMALE: NA	23c. If yes, outcome o	of pregnancy		N/A	-		
O. Box	The law requires that the death certify the seventify the stending to a sound be detached for use as age?	Physician/M	23b. Was decedent pregnant in the past 12 months?  1 Yes 2 No 9 Unknown	1 ☐ Live birth 2 4 ☐ Pregnant at t 9 ☐ Unknown	2 Fetal death 3	☐Ectopic pregnancy ☐ Other (specify)	10 1.5		23d. Date of Month	Day Year
Vital Records, P.	quires that in signed b	ompleted by PI	Part II. Other significant conditions co	5 Den	nentia	underlying cause giv	en in Part I.	23e. Did toba 1 ☐ Yes		te to the cause of death?  Probably 4 □Unknown
eco	law requir nas been si e 2 should	nplet	chronic De	bility				24a. Was an autopsy	prior	a autopsy findings available to completion of cause of
<u> </u>		e Cor	25. Was case referred to medical	1			00.01		No 10	
	Physicie this cert al directo	To Be	examiner?	Hospital: Inpatier	nt 2 ER/Outpati	ent 3 DOA Oth	0.00	n <i>(Check only one)</i> me 5 ☐ Residen		Specify)
on of	ding I h. After funer		27. Manner of Death  1 Naturat 5 Pending 2 Accident investigation	28a. Date of Injury (Month, Day	Year) 28b. Time Injury	Worl		28d. Describe how		
Division	To the Hospitel or Attenwithin 24 hours after deat To the Funeral Director: completely filled in by the	Certification:	3 Suicide 6 Could not be determined	28e. Place of Injur	ry - At home, farm, : . (Specify)			28f. Location (Stre City or Town,	et and Number o	r Rural Route Number,
<b>a</b>	e Hospitel or 24 hours affe e Funeral Dir etely filled in		29a. Certifier 1 ★ Certifying Phy	sician: To the best of	f my knowledge, de	ath occurred at the tin	ne, date and place,	and due to the cau	se(s) and manne	r as stated.
	vithin 24 h	ledical	(Check only 2 Medical Exemi	ner: On the basis of and manner stat	examination and/or	nvestigation, in my o	pinion, death occurr	ed at the time, date	e and place, and	due to the cause(s)
	To the within To the compl	Σ	29b. Signature and title of certifier	h	m.D	29c. Licens		290	d. Date signed (M	onth, Day, Year)
, 1	T		30. Name and address of person who co	ompleted cause of de	ath (Item 23a) (Type	a, Print)	20271		2	2,2006 1D21044
<b>₩</b>	192		Harry Li, 31. Date filed (Modith, Day, Year)	10780 H	r's Signature	ridge 1	ed, co	lumbia	$\sim$ , N	1021044
3	Sta Registr		JUL 2 6 200	16	J. 6	sails				

			1 - For State Registrar	State of Ma	aryland .		rtment			and M	lental l		ene ()	06	23	474
	Physici /Medi	cal		n, Jr.			41- 02-	T	Lastin	(5-4)	2. Date of Month July		<sup>Day</sup> 2006	Year		of Death
	Examir Funeral	er	4a. Facility Name (If not institution, give s  Oak Crest Care Cer  5. Social Security Number 6. Sex	nter 7. Age	(In yrs. last	t birthday)	Balt	timon	re Co	unty	8. Date o	f Birth	4c. County Balti	more	place (State	or Foreign
14.0	Director		215 16 7102 1X  Usual Residence of Decedent  10a. State 10b. County	<sup>1M 2□F</sup> 85	10c. City, T	Yrs.	Months	Days	Hours	Min.	May 8	1921	ear)		od. Inside	Marylan  City Limits
	with the Mary a or 28a-f sho be notified a	Funeral Director	Maryland Baltimore  10e. Street and Number		Baltir	moire G	ounty 10f. Zip 212						. Citizen of		1 🗌 Ye	es 2 X No
0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: if item 27 is marked other than "natural", or itams 23a or 28a-f show any injury or other traumatic event, the Medical Exemitar must be notified at 2008.	þ	1 □ Never Married 2 □ Married 3 ★ Widowed 4 □ Divorced	12. Was Decedent E Armed Forces? 1 ∰Yes 2 □ N If Yes, Give Year or Dates: ¶	WII	1	Vas Deced Yes, spec	lent of His ify Cubar 2[XNo		gin? (Spe i, Puerto I	cify Yes o Rican, etc.	No-	Specif	e - Americ ck, White,	etc.	
d 21215-	the filed within 72 half Hygiene.  ed other than "nate: event, the Medical	Completed	15. Decedent's Educify only highest grade  Elementary/Secondary (0-12)  12  17. Father's Name (First, Middle, Last)			6a. Deced (Give I life. D	kind of wor OO NOT us	k done d	uring most			В	b. Kind of B altimor	e Co.	·	ept.
arylano	should be to the Mental I was marked o umatic eve	To Be	George A Klein Sr  19a. Informant's Name/Relationship (Type)	pe, Print)		19b. Mailin	g Address	(Street a	Anna	M. Bo	odkme:	yer	ity or Town,		Code)	
Baltimore, Maryland 21215-0036	Pages 1 and 2 ment of Health a lant: if item 27 is lury or other trai		Mary A Overcash  20a. Method of Disposition  1 図 Burial 2 □ Cremation 3 □ R  4 □ Donation 5 □ Other (Specify)	Removal from State (St. Joseph Ch. Cem. July 27 2006)  Balti							land 21 c. Location ltimore	City or To				
Balt	permit. Departr imports any inju		21. So at the of Funeral Service License  23a. Part1. Enter the disease, or compli	ho Chor	1000	2 74	01 Bel.	air R	oad Ba	ltimo	re, M	ryla	nd 2123	6	Approxim	210
8760,	Physician /Medical Examiner		shock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, in the cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a	e.  2 ) ( )  a consequent  consequent	ce of:		o or dying	, 3001 43	cardiac o	Төэрлаго	ny alles			Interval Br Onset and	etween
P.O. Box 68	The law requires that the death certifics are has been signed by the attending ptrage 2 should be detached for use as it.	Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 □ No 9 □ Unknown	Ectopic pregnancy Other (specify)							te of delive	ery Day	Year			
	w requires that been signed b should be deta	۵	Part II. Other significant conditions con	tributing to death bu			derlying ca	ause give	n in Part I.			Oid tobac	2 No		ne cause of	
tal Rec	rician: The law certificete has b rector, page 2 st	Be Completed	25. Was case referred to medical						26. Place	of Death	1 U Y		d?	prior to cor death?	psy finding npletion of 2 No	available cause of
Division of Vital Records,	ttending Physical death.	Certification: To E	examiner?  1								mber,					
ā	To the Hospital or A within 24 hours after To the Funeral Direct Completely filled in by	edical Cer	29a. Certifier 1 ertitying Phys (Check only 2 Medical Examir	sicien: To the best of	f my knowled	dge, death and/or inv	estigation,	at the tim in my op	a date and	d plana, a	nd duste	the asus	ialist and co	inhar 15 st and due to	ulad.	(s)
•	Mithin 2 To the complete	Med	29b. Signature and title of certifier  30. Name and address of person who co	and manner star	(led.		29c.	License				-,	Date signe			> C
	Sta Registi		31. Date filed (Month, Day, Year)  JUL 2 6 200	32 egistra		Un 1	the s	C	boul	ی صرا	e (J		Post	, i (1)	ar about	12074

			Please	State of M		l / Depa	rtment of I	Health and I	•	_	ible.	0175
			Registrar			Cer	tificate of	Death		Reg. No.	Ub . 2	01410
	Physicia /Medic		1. Decedent's Name (First, Middle, La  John C. Kobbe						2. Date of De Month	Day	Year	Time of Death
	Examin	er	4a. Facility Name (If not institution, giv					or Location of Deat	1		ty of Death	
14.			Upper Chesapeake				Bel A		1		ford	
MG	Funeral Director		5. Social Security Number  132-14-8573  Usual Residence of Decedent	DM ODE	ge (In yrs. Ia.	Yrs.	If Under 1 Year Months Days		8. Date of Bir (Month, Da Mar. 26	1925	9. Birthplace ( Country) New Yo	State or Foreign rk
m 2	land ow		10a. State 10b. County		10c. City,	Town or Loc	ation				10d. In:	side City Limits
No Po	ath with the Marylar 23a or 28a-f show	Funeral Director	Md. Harford	d 		Bel Ai				10a Chiana at		Yes 2□No
18-3	with	급		<b>+</b>			10f. Zip Code	21014		Harf	What Country?	
4 %	leath	era	801D Almond Cour	12. Was Decedent	t Ever in U.S.	13 V			necify Yes or No		ice - American Inc	tian
38 26	72 hours after death with the Maryland natural', or items 23a or 28a-f ehow dical Examiner must be notified at	þ	1 Never Married 2 Married 3 Widowed 4 Divorced	Armed Forces 1 XYes 2 ☐ ff Yes, Give Year or Dates:	?  No	If	Yes, specify Cub	Hispanic Origin? (S pan, Mexican, Puert Specify:	Rican, etc.)	Speci	ack, White, etc.	·
£ 15-0	iin 72 ho n "naturi dedical i	Completed	15. Decedent's Ed (Specify only highest gra	ide completed)		16a. Deced (Give I life. D	ent's Usual Occu kind of work done OO NOT use retire	pation during most of world)	king	16b. Kind of I	Business/Industry	
212	d within giene.	E	Elementary/Secondary (0-12)	College (1-4or		servi	e manag	er		autom	otive	
ک کو	be filed tal Hygid d other	Be C	17. Father's Name (First, Middle, Last)	)				18. Mother's Nar	ne (First, Middle,	Maiden Suma	me)	
a S	Wental Wental urked utlc ev	일	Max Kobbe					Mary F	urpina			
Man	nd 2 sho alth and 27 le mu ir treuma		19a. Informant's Name/Relationship ( Karen Litz/daugh			19b. Mailin 813 I	g Address <i>(Street</i> Brentwoo	t and Number or Ru d Park Dr	ral Route Numberive, Bel	er, City or Town	n, State, Zip Code, Md. 2101	4
G Tore,	ages 1 and of He		20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 3 ☐		cen	netery, crem	sition (Name of satory or other pla		Date / 2006		- City or Town, Si	tate
30 0¢  Baltimo	artmen ortant: injury		4 □ Donation 5 □ Other (Specify 21. Signature of Funeral Service Licer		pel		Iem. Gdn.		72000	Bel Ai	I, FIG.	
B C	permit. I Departra Importa any injua		) ////			So	chimunek	Funeral				
- CO			23a. Part1. Enter the disease, or com	plications that care	d the death.	Do not ente	O W. Ma	cPhail Ro	ad, Bel	Air, M		oximate
7	Physician		fmmediate Cause (Final	one cause on each I	line.	. /	Á J.	1211	1. 7	- 1 1	Inten Onse	val Between et and Death
	/Medical		disease or condition resulting in death)	a. Type	Kal en	nce of	TZaterni	4/1/e/40	olic 1	ma ala	nce 24	House
	Examiner		One anti-the link and distant	- Changi	c Ro		Fail	der.			2	Werds
0	D #	ner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as	s a conseque	nce of):	1 7	1	Λ (			1
13	sicien and burial-transit	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c. Empo	lizati	eu	to K	enel	Arter	ies	3	Weeks
7	be ex cien a	ai E		Due to (or as	1	nce of):	1	1	A		71	/
289	ntificate ng physi es the b		•	d. Duph	arene	AS	danel	Mous	Le It	reung	an of	ears
OFF.	ath ce	Physician/Medic	1F FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 155No 9 □ Unknown	23c. If yes, outcome 1□Live birth 4□Pregnant a 9□Unknown	2 Fetal d	eath 3 🗆	Ectopic pregnanc Other (specify)	у			ate of delivery onth Day	Year
5 0	that the de ned by the a		Part II. Other significant conditions of	ontributing to death I	but not result	ing in the un	derlying cause gr	ven in Part I.	23e. Did to	obacco use con	tribute to the caus	se of death?
Frds	quires n n signe	0	Parax egia	Seand	y f	-6	recent	5	1	res 2□No	3 Probably	
200	sw requir	Completed	Thomasold		Azo	· (4. s	Ros	× Xno.	24a. Was	an 24b.	Were autopsy fin	dinos available
- Be	The lar	mo du	100000000000000000000000000000000000000	Commi	11 ~~	- June	140	Co New	autop perfo	rmed?	prior to completion death?	on of cause of
$\frac{1}{2}$	lician: Th certificate rector, pag	0	25. Was case referred to medical					26. Place of Dea		2 No	1 ☐ Yes 2 ☐ N	lo
Ø ≥	Physician: this certific al director.	To B	examiner? 1 ☐ Yes 2 MNo	Hospital: 1 Nonpati	ent 2 E	R/Outpatient	3□ DOA Ott		ome 5 Resid		her (Specify)	
000	ding Ph J. After th funeral		27. Manner of D ath  Datural 5 □ Pending	28a. Date of Inju (Month, Da	ury 2 ay Year)	8b. Time of fnjury	28c. fnju Wo		28d. Describe t			
Si O	Attending is death.  ector: After by the fune	catic	2 Accident investigation	٦				Yes 2 □No				
XI	s after d el Direct ed in by I	Certification:	3 Suicide 6 Could not be 4 Homicide determined	28e. Place of in	jury - At hom tc. (Specify)	e, farm, stre	et, factory, office		28f. Location (S City or Tox	Street and Num vn, State)	ber or Rural Route	e Number,
	To the Hospitel or within 24 hours after To the Funerel Director of the Funerel Director of the Funerel Director of the Funerel Director of the Funerel Director of the Funerel Or of the Funere	Medicai	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	nysician: To the best niner: On the basis of and manner si	of examinatio	edge, death n and/or inv	occurred at the ti estigation, in my o	me, date and place opinion, death occu	and due to the rred at the time,	cause(s) and m date and place,	anner as stated. and due to the ca	ause(s)
	To th withir To th	Ň	29b. Signature and title of centrer	1)			29c. Licens	se number		_	ed (Month, Dey, Y	
			Taxede	Ville M	D		D	3065.	3	June	21,2	006
-	$ \langle V \rangle $			completed cause of	death (Item 2	(Type, F	rint)	<i>i-i</i> 1	~	70 (	Λ	. /
	$\cup$		Koply En Solm	eider M	-	520	Upper C	hegapeake	Prive	, tel	Hir, 1	Tangland
	Sta Registr	_	31. Date filed (Month, Day, Year)  JUL 2 6 2006		rar's Signatu		,	,		•		

Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. Amend Item State of Maryland / Department of Health and Mental Hygiene 2 (1) (1) (24a, 25 per Dr., 6857.07/26/06ahb Reg. No. 23475 1 - For State Registrar 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death OTHY **Physician** Rebecca ewis 1214 PM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City. Town, or Location of Death Examiner Baltmora Sira; Hospital Baltmore Tot If Under 1 Year | If Under 24 Hrs. 6. Sex 8. Date of Birth (Month Day, Year) 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) Funeral 1□ M 2□€ Months Days Hours 215-14-5695 Usual Residence of Decedent Director Maryland 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits 28a-f show the Medical Examiner must be notified at 1XYes 2 □ No Completed by Funeral Director timore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 5101 leville Avenue Iteme 23a 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 No If Yes, Give Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, 11. Marital Status Black, White, etc. 1 Never Married 2 Married 21215-0036 ŏ 1 ☐ Yes 2 KNo Specify: yacl 3 Vidowed 4 □ Divorced 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry al Hygiene. Elementary/Secondary (0-12) College (1-4or 5+) Dervisor traumatic event, land 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Mail Be 2 should be fi and Mental H is marked of 9b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3210 item 27 other 20c. Location - City or Town, State 20a. Method of Disposition

1 Burial 2 Cremation spartment o importent: if ite any injury or once. 3 Removal from State Cemetray 4 ☐ Donation 5 ☐ Other (Specify) 22 Name and Address of Facilly MB094 BUDNO 11223 Stric ter complications that caused the death. Do not enter only one cause on each line. 23a. Part1. Enter the disease, or com shock, or leart failure. List only Approximate Interval Between Onset and Death such as cardiac or respiratory arrest, Immediate Cause (Final disease or condition resulting in death) Physician Due to (or as a consequence of): Drona /Medical Examiner Q -- plus consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Examiner burial-transit Due to (or as a consequence of): Physician/Medical use as the IF FEMALE 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months?
1 Yes 2 640
9 Unknown Month Year 4☐Pregnant at time of death 5 Other (specify) signed t Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? ģ 1 Yes 2 No 3 Probably 4 Onknown page 2 should Completed 24a. Was an autopsy performed? 24b. Were autopsy findings available prior to completion of cause of death? 2 No 1 Yes Vital 1 ☐ Yes ★★No funeral director. 25. Was case referred to medical Be 26. Place of Death (Check only one) examiner? Other: 4 Nursing Home 5 Residence 6 Other (Specify) ၀ 1 ☐ Yes 2 → No 1 Inpatient P/Outpatient 3 DOA this ŏ 28c. Injury at Work? 28a. Date of Injury (Month, Day Year) 27. Manner of Death 28b. Time of 28d. Describe how injury occurred Certification: Division Hospitel or Atlending 1 Natural 2 Accident Injury 5 Pending 1 ☐ Yes 2 ☐ No hours efter death. investigation 9 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number. City or Town, State) à 4 Homicide ithin 24 hours e Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medicai ripletely (Check only 29b. Signature and title of certifier 29d. Date signed (Month, Day, Year) ps MD 30. Name and address of person who completed cause of death (Item, 23a) (Type, Print) inci Hospital Matthaw 31. Date filed (Month, Day, Year) 32. Registrar's Signature Registrar 2 6 2006

DHMH 17 Rev 1/2001

			For Stete Registrar	State of M	laryland		artment of I		and Me		iene	06	23477
			Hegistrar     Decedent's Name (First, Middle	, Last)						2. Date of Dear	th		3. Time of Death
	Physicia		Rose Mary Lanc	elotta						July 2	Day 4. 200	Yeer 6	7:00 A <sup>M</sup>
	/Medic Examin		4a. Facility Name (If not institution,		r)		4b. City, Town,	or Location o	of Death		1-	ity of Death	
			220 S. High St	reet			Baltin						
	Funeral		5. Social Security Number	4 THA STORE	ge (In yrs. las.	t birthday) Yrs.	If Under 1 Year Months Days	If Under a	Min.	8. Date of Birth (Month, Day)	Year)	Cou	place (State or Foreign untry)
	Director		212-01-0575 Usual Residence of Decedent		94	115.			]1	Dec. 1,	1911	Mary	Land
	land		10a. State 10b. County		10c. City, 7	Town or Lo	ocation						10d. Inside City Limits
	Mary -f sh	ō	Maryland		В	alti:	more						1 ☑ Yes 2 ☐ No
	h the	Director	10e. Street and Number				10f. Zip Code			1	0g. Citizen o	f What Cou	untry?
	23a c	alD	220 S. High Str				2120				USA		
	tems	nue	11. Marital Status	12. Was Deceder Armed Forces	5?	13.	Was Decedent of If Yes, specify Cut	Hispanic Ori oan, Mexican	gin? (Spec 1, Puerto F	cify Yes or No- Rican, etc.)		ace - Amer lack, White	ican Indian, , etc.
36	s afte	by Funeral	1 ☐ Never Married 2 ☐ Marri 3 ☑ Widowed 4 ☐ Divorced	ed 1 ☐ Yes 2 ☑ If Yes, Give Year or Dates			1 ☐ Yes 2 🖾 No	Specify:			Spec	city:	White
21215-0036	within 72 hours after death with the Maryland ene. then "neturel", or items 23a or 28e-f show he Madical Examerational be notified at	edt	15. Decedent			16a. Dece	dent's Usual Occu	pation			16b. Kind of	Business/I	ndustry
15	nin 72 n "ne Madik	Completed	(Specify only highes		r 54)	(Give life.	kind of work done DO NOT use retire	during most d)	t of workin	g			
212	e filed within al Hygiene. I other then "	ĕ	Elementary/Secondary (0-12)	Jonego (1 40		Hom	emaker				Own	Home	
2	be filed tal Hygid of other event, I	Be	17. Father's Name (First, Middle,	Last)				18. Mothe	r's Name	(First, Middle,	<b>Ma</b> iden Sum	атө)	
ya	2 should be and Mental Is marked eumatic ev	ဂ္	Joseph Pente							berto			
Maryland	s 1 and 2 should be filed within 72 hours after death with the Marylan if Health and Mental Hyglene. Item 27 is marked other then "neturel", or Items 23a or 28e-f show other treumatic event, I're Medical Example at monther recitified at		19a. Informant's Name/Relationsh		171		ng Address (Stree				-		ip Code)
	s 1 and 2 of Health a item 27 ls other tree	1	Raymond Lancelo  20a. Method of Disposition	otta Son			Highpoin osition (Name of	t Road			MD 2 20c. Locatio		Town. State
و	ages or of B		1 X Burial 2 ☐ Cremation		cem	netery, cre	matory or other pla of Faith	<sup>(109)</sup> 7	<sup>7</sup> -28/			-	Maryland
Baltimore,	it. Partmer		' 4 □ Donation 5 □ Other (Si		201			ess of Facilit	Ster.	ling As	hton S	chwab	Witzke
Ba	permit. Pages Department of H Important: If ite any injury or of		lence	to	11		Funeral 1630 Ed	Home mondso	of Ca	atonsvi enue; C	lle,In atonsv	iile,	Witzke MD 21228
Ī	Pnysician		23a. Part1. Enter the disease, or shock, or heart failure. List Immediate Cause (Final	complications that caus only one cause on each	ed the death. line.	1 1	-	ing, such as	1	respiratory arr			Approximate Interval Between Onset and Death
	/Medical Examiner		disease or condition resulting in death)		as a consequent		Heart F	1	-				10 recons
		Je.	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying	b. Due to (or a	as a conseque	nce of):							
	ate be executed hysician and the burial-transit	Examiner	Cause (Disease or injury that initiated events	с									
,092	e exe sian a urial-i		resulting in death) Last	Due to (or a	as a conseque	nce of):							
876	cate b chysic the b	dlcal		d									
89 X	death certifical e attending phi id for use as th	Physician/Med	IF FEMALE:	23c. If yes, outcom	ne of pregnanc	y					23d. I	Date of deli-	very
Вох	atten after of for u	ciar	23b. Was decedent pregnant in the past 12 p onths? 1 ☐ Yes 2 ☑ No		2 Fetal de at time of dear		□Ectopic pregnand □ Other (specify)	су				Month	Day Year
0	at the de by the a tached f	hysi	9 ☐ Unknown	9□ Unknown									
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CO	swrequir s been si 2 should	Completed								24a. Was a	in 24	b. Were aut	topsy findings available ompletion of cause of
	The lavate has	E								perfor		death?	2□ No
Vital		Bec	25. Was case referred to medical examiner?						of Death	(Check only or	ne)		
of <	Physician: rthis certific ral director,	2	1 ☐ Yes 2 ☐ No	Hospital:		-VOutpatie	nt 3 DOA			ne 5 Resid			rity)
	ding Ph h. After th funeral	on:	27. May r of Death 1 Natural 5 ☐ Pendin		njury Da <i>y Ye</i> ar)	8b. Time o Injury	W	ury at ork? ]Yes 2 □:		8d. Describe h	ow injury occ	urred	
Sio	or:	cat	2 ☐ Accident investig 3 ☐ Suicide 6 ☐ Could	not be One Place of	Injuny - At hom	o farm et	M 1 [		_	8f. Location (S	treet and Nu	m <i>her or R</i> u	ral Route Number,
Division	after de Direct	Certification;	4 ☐ Homicide determ		etc. (Specify)	o, iaiii, si	real, radiory, onio	,		City or Tow	n, State)		
	To the Hospitel or a within 24 hours after To the Funerel Direction Completely filled in L	edical C	29a. Certifier 1 Certifyin (Check only one)	ng Physician: To the be Examiner: On the basis and manner	of examinatio	edge, dear n and/or in	th occurred at the nvestigation, in my	time, date an opinion, dea	nd place, a th occurre	nd due to the co	ause(s) and ate and plac	manner as e, and due	stated. to the cause(s)
	To the within To the comple	Me	29b. Signature and title of certifie	1111	Cert	fxy		se number	000	0100	9d. Date sig		
),	1		1/100/11/1	und atolli,		- Clay				8673	JUX 2	2,20	06
	U			OLDNOED,	m.D	6901	N. Charles	S7, SI	vite 5	105	paltina	( Illa	13/1907
8	Sta Regista		31. Date filed (Month, Day, Year)  JUL 2 6	2006 32 Regi	strar's Signatur	do do	ale						J

	1	- Stote Amend item#7, perl		6 TI Cer	tificate of	Death	R	eg. No.						
Physiciar /Medica	n	Decedent's Name (First, Middle, Last,     Chong Sun	, Lim				2. Date of Dea Month July 21	Day	Year	3. Time of Death 10:10a M				
Examine	16	4a. Facility Name (If not institution, give			•	or Location of Death		4c. County						
Ř 25		5801 Security Blvd			Gwynn If Under 1 Year		1	Balti						
uneral rector		21/-11-/120	7. Age (III	yrs. last birthday) Yrs.	Months Days		8. Date of Birth (Month, Day OCt. 21	Year 1944	9. Birthp Cour Kore	place (State or Foreign ntry) a				
3	-	Usuat Residence of Decedent  10a, State 10b, County	10	c. City, Town or Lo	cation				1	0d. Inside City Limits				
natural, or itama 23s or 28s-f show	ō	Maryland Howard		Ellicott						1 ☐ Yes 2 ☑ No				
Hor	Director	10e. Street and Number			10f. Zip Code		1	0g. Citizen of W	hat Cour	ntry?				
at he		2388 Ballard Way			210	042		USA						
aciner os	by Funeral	11. Marital Status  1 Never Married 2 Marned	12. Was Decedent Eve Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give	t	Nas Decedent of f Yes, specify Cu	Hispanic Origin? (Siban, Mexican, Puerto Specify:	pecify Yes or No- o Rican, etc.)		c, White,					
1		3 Widowed 4 Divorced	Year or Dates:		lent's Usual Occi			16b. Kind of Bu		ian				
Te Medical	Completed	(Specify only highest grad	le completed)	(Give	kind of work don DO NOT use retir	e during most of wor	king	160. Kind of Bus	21116224111	uusiry				
Te .	E	Elementary/Secondary (0-12)	College (1-4or 5+)	Owner				Self- e	mplo	yed				
	Bec	17. Father's Name (First, Middle, Last)					ne (First, Middle, i	Maiden Surname	9)					
	0	Kwang Sung Joo				Oak Su	n Park							
traumatic		19a. Informant's Name/Relationship (7)				et and Number or Ru	ral Route Number	, City or Town, S	State, Zip	Code)				
other t	-	Tae Jong Lim- son  20a. Method of Disposition	2301 Champ	ain St.,	NF Unit	301, Was	bington,	DC 200	09 City or To	our State				
5		N□ Burial 2 □ Cremation 3 □ F	Removal from State	cemetery, cren	natory`or other pl				•					
	1	4 ☐ Donation 5 ☐ Other (Specify)  21. Signature of Fune ☐ ervice Licens		Crestlawn M	. Name and Add		/2006 M	arriott	SVII	re, MD				
BUG		b mym		Ga	ry L. Ka	aufman Fun	eral Hom	e at MM	P, I	NC.				
4.1	-	23a. Part1. Enter the disease, or comp	ications that caused the	death. Do not ent	50 Washi	ngton BLV	D. Elkr	idge, M	D 21	075 Approximate				
		shock, or heart failure. List only o Immediate Cause (Final	ne cause on each line.	1 1		o bascy				Interval Between Onset and Death				
an cal	İ	disease or condition resulting in death)	Due to (or as a co	clenatic	C Wal	o ousch	(a) his	علالاتحالا		10 years				
er		Sequentially list conditions.												
	ner	Sequentially list conditions,  Due to (or as a consequence of): cause. Enter Underlying												
	Examiner	Cause (Disease or injury that initiated events resulting in death) Last	c						_					
		18 SUILING III GBALII) LASL	Due to (or as a co	nsequence of):										
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		IF FEMALE:	23c. If yes, outcome of p	regnancy				22d Date	a of dolars					
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	lysic	1 □ Yes 2 □ No 9 □ Unknown	9□ Unknown	0.000	Surer (speeny)	-								
detached	by Pr	Part II. Other significant conditions co	ntributing to death but n	ot resulting in the u	nderlying cause g	given in Part I.	23 <i>e</i> . Did to	pacco use contri	ibute to th	ne cause of death?				
5 1							1 🗆 Y	9s 2□No	3 🗌 Prob	pably 4 Unknown				
Dinguis de la companya de la company	Completed						24a. Was a	n 24b. W	Vere auto	psy findings available				
bage	Ĕ						autops	ned? d	eath?	mpletion of cause of				
9	0	25. Was case referred to medical				26. Place of Dea	1 ☐ Yes :	750-00-0	□ Y <i>e</i> s	2 No				
	ToB	examiner? 1 Yes 2 No	Hospital: 1 ☐ Inpatient	t 3 DOA	ther: 4 Nursing H	V	ence 6 □Othe	r (Specifi	iv)					
		27. Manner of Death	28a. Date of Injury (Month, Day Ye	28b. Time of Injury		ury at	28d. Describe ho			,,,				
	atlo	1 Natural 5 Pending 2 Accident investigation	(Month, Day 10	any injury		Yes 2 □No								
	Certification;	3 Suicide 6 Could not be determined	28e. Ptace of Injury building, etc. (5		eet, factory, office	9	28f. Location (St City or Town	reet and Numbe	or Rura	d Route Number,				
	Č		, tue (-	,,,,	City or Town, State)									
Bly III		(Check only 2 Medical Exemi	sician: To the best of miner: On the basis of ex											
completely tilled in by the	Medicai	one)	and manner stated			ns <i>e</i> number								
3		29b. Signature and the of certifier	1 - 1		29C. LICHI	011-		9d. Date signed						
K		(W)	Deput	1	U	5661	ithervill	July Z	12,2	2006				
		30. Name and address of person who o	4	3 3 1/		1.	4) (1)	0.5	, -,	1003				
Stat		31. Date filed (Month, Day, Year)	32. Registrar's	signature	1 6 6	<i>L</i> 1	unervill	0,141)	٠, ح	107-3				
	e	31. Date filed (Month, Day, Year)	2000 32. Hegestrar's	aignature /	1									

State of Maryland / Department of Health and Mental Hygiene UUD For State Registrar Certificate of Death 2. Date of Death 1. Decedent's Name (First, Middle, Last) 3. Time of Death Physician Chong 0701 AM Eun 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4b. City, Town, or Location of Death 4c. County of Death Examiner Union Memorial Hospital Baltimore | If Under 1 Year | If Under 24 Hrs. | 8. Date of Birth (Month, Day, Year) | 9. Birthplac (Month, Day, Year) | 4. Country, April 15, 1913 | 1. Korea 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 □ M Yrs. 220-06-9327 93 Director Usual Residence of Decedent permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If item 27 is marked other than "natural" ~ "" en yillury or other traumatic event." 10a. State 10c. City, Town or Location 10b. County 10d. Inside City Limits Maryland Baltimore Completed by Funeral Director 1. Yes 2 □ No 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 1239 W. Baltimore St 21223 USA 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☐ No If Yes, Give X Year or Dates: Was Decedent of Hispanic Origin? (Specify Yes or No If Yes, specify Cuban, Mexican, Puerto Rican, etc.) Race - American Indian, Black, White, etc. 1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 ☐ No Specify: 3 ₩Widowed 4 Divorced Asian 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) 0 Homemaker Own Home 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Surname, Be Unknown Lee unknown ဥ 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) Byung Chung-daughter 1239 W. Baltimore St., Baltimore, MD 21223 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 ☐ Other (Specify) 7/26/2006 Metro Crematory Catonsville, MD 21. Signature of Funeral Sprvice Licensee 22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, INC. 7250 Washington Blvd., Elkridge, MD 21075 23a. Part1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) Pnysician Sep515 /Medical Due to (or as a consequence of): Examiner PNEUMONIA PITOTION Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to ( as a consequence of): Examiner or Attending Physicien: The law requires that the death certificate be executed attending physicien and for use as the burial-transit mentia Due to (or as a consequence of): P.O. Box 68760. Physician/Medical IF FEMALE: 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal death 23d. Date of delivery 23b. Was decedent pregnant 3 Ectopic pregnancy in the past 12 months? Month Day Year 4☐Pregnant at time of death 5 Other (specify) sete has been signed by the a page 2 should be detached in 9 Unknown 9 Unknow Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? Completed by Division of Vital Records, 2 X No 1 Tyes 3 ☐ Probably 4 ☐ Unknown certificete has been 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an autopsy perform 20 1 ☐ Yes 2 ☐ No 1 ☐ Yes : After this certifice funeral director, p Medical Certification; To Be 25. Was case referred to medical examiner? 26. Place of Death (Check only one) Other: 4 Nursing Home 5 Residence 6 Other (Specify) Hospital: 2 No 1 Tes 1 Inpatient 2 X ER/Outpatient 3 □ DOA 27. Manner of Death 1 X Natural 2 Accident 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred To the Hospitel or Autonomic within 24 hours effect death.

To the Funeral Director; Aftr 5 Pending 1 ☐ Yes 2 ☐ No investigation 6 Could not be determined 3 Suicide Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) 4 | Homicide Tertifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) M.D. D0053373 22 2006 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) Paul Kang, M. D. University tarkway East Baltimore, MD Registrar's Signature 31. Date filed (Month, Day, Year)
JUL 2 6 2006 State

DHMH 17 Rev 1/2001

Registrar

0345

### 06-05177

Thomas H Legall

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		- For State	,,,,,	Certif	icate of Death		Re	g. No.	IS DOLB
Physician Medical Examine	/	I. Decedent's Name (First, Middl THOMAS		н.	LEGALL		2. Date of Death Month July 18, 20	Day Year	3. Time of Death
Marie Salah		4a. Facility Name (if not institution			4b. City, Town,	or Location of Dea		4c. County of Dea	ith
<b>.</b>	Ļ	5516 Pioneer Drive  5. Social Security Number	6. Sex 7.	Age (In yrs. last I	Baltimore birthday) If Under 1 Ye	ear If Under 24H	rs 8 Date of Birt	NA h(MM/DD/YYYY) 9. E	irthplace (State or
Funeral Director		126-28-5669	1 X M 2 F	70				Fore	
any	_	Usual Residence of Decedent  10a. State 10b. County		10c. City, Tox	wn or Location				10d Inside City Limits
Maryland 28a-f show any d at once.	<u>.</u>	Md.	NA		Baltimore				1 X Yes 2 No
h the Maryland 3a or 28a-f sh otified at once		ice. Street and Number 5516 Pioneer D	rive		10f. Zip Code 21	214	10	g. Citizen of What Co USA	untry?
or death with , or items 23 r must be no	miera	Marital Status     Never Married 2 Married	arried Armed Ford	ent Ever in U.S. es? 2 X No	13. Was Decedent of I	an, Mexican, Puer		White, etc.	erican Indian, Black,
urs after ural", uniner		3 Widowed 4 N Div	orced If Yes, Give Year or Dates: ocify only highest grade	completed) 16	1 Yes 2 X N		f work done	Specify. B	Lack
5-0036 ed within 72 hours aft tygene of the than "natural" the Medical Examine from Manada have	herec	Elementary/Secondary (0-12) 12th grade			during most of working li Mechanic E	fe DO NOT use re		Lucent 1	,
21215-0036 hould be filed within 72 nd Mental Hygene in marked other than attic event, the Medical		17. Father's Name (First, Middle, Abraham	Theodor	e	LeGall	18.Mother's Nar Charl	ne (First, Middle, M otte	laiden Surname) Gladys	Williams
MD 21 nd 2 should B alth and Mer m 27 is mar aumatic eve		19a. Informant's Name/Relations Shirlene Faith		Daughter	19b. Mailing Address (Str 410 Macon				te, Zip Code) L1233
Baltimore, MD 21215-0036  Permit Pages I and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene Important: If viem 27 is marked other than "natural", or items 23a or 28a-f sho injury or other traumatic event, the Medical Examiner must be notified at once.		20a. Method of Disposition  1 Burial 2 X Cremation  4 Donation 5 Other Sp		State crer	ce of Disposition (Name of on natory or other place) enmount Cem.		Date -25-06	20c. Location - City of Baltimore	
Baltii permit Departm Imports		21. Signature of Funeral Service	more, Md. E. North	21202 Ave.					
Physician /Medical		23a. Part I. Enter the disease, or failure. List only one cause	on each line.			g, such as cardiac	or respiratory arre	st, shock, or heart	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. Atherosclero		cular Disease				Deatri
(C. 2/ )		Sequentially list conditions, if any, leading to immediate	b	onsequence of):					
		cause Enter Underlying Cause (Disease or injury that initiated	e				····		./4
uted ansit	EX E	events resulting in death) Last	Due to (or as a co	onsequence of):					
760, frost be executed g physician and the burial - transit		UNPENDED	AMENDED						
		F FEMALE: 3b. Was decedent pregnant in th		tcome of pregnan		Ectopic preg	nancy	23d. Date of delive	ny Day Year
Vital Records, P.O. Box 68 hysician: The law requires that the death certificate this certificate has been signed by the attending Lidirector, page 2 should be detached for use as To Boy Completed by Deutsisian	Physician	past 12 months?  1 Yes 2 No 9 Uni	4 Pregnar	it at time of death				l.	
hat the ced by the letached	5	Part II. Other significant condit	tions contributing to d	eath but not resul	Iting in the underlying cause	e given in Part I.		bacco use contribute t	
duires t							Yes 24a Was a		obably 4  Unknown autopsy findings available
COFC	Completed						autops perfor	sy prior to med? death?	completion of cause of
I Re	<u></u> -	25. Was case referred to medica	al		26.Pla	ce of Death (Chec	1 Yes 2	No 1 V	Yes 2 No
Vita hysicia this cer		examiner? 1 ✓ Yes 2 No	Hospital: 1 Inp	atient 2 ER	R/Outpatient 3 DOA	Othor		Residence 6 🗸 Oth	er. Scene
on of onding Ph. ath. After the funeral		27. Manner of Death  1 V Natural 5 Pend		Injury 28 ay,Year)		jury at Work? Yes 2 No	28d Describe h	ow injury occurred	
Division of Vital Records, P.O. tall or Attending Physician: The law requires that the start death.  The ran brector: After this certificate has been signed by lled in by the funeral director, page 2 should be detach	Certification:	3 Suicide 6 Coul	estigation 28e. Place of (Specify)	of Injury - At home	e, farm, street, factory, office	building, etc.	28f. Location (S or Town, St		Rural Route Number, City
	Medical	29a Certifier 1 Certifying P	aminer:On the basis of	examination and/	death occurred at the time, or investigation, in my opini				
F. W. F. S.	Z -	295 Signature and title of certific	and manner state	<u>ea</u>	29c. Lice	nse number		29d. Date signed (M	onth, Day, Year)
	-	39. Name and address of person	ewb)	of death (Item 23		C.M.E.		July 19, 2006	
20			Assistant Medical		111 Penn Street, Bal	timore, MD 21	201		
Star Registra	te ar	31. Date filed (Month, Day, Year)	2006 32 Reg	strar's Signatu	Speaker				

		for State	State of Marylar						(m U)	06 2	3481
		1. Decedent's Name (First, Middle, Las	<u>20a Per FH G8'</u>	57 1926	006 91	noi Dear	.,,	2. Date of Dea			e of Death
Physic		0 1						Month 9	2 RAID 2	Veer 5.3	M A O
/Med Exam		4a. Fecility Name (If not institution, give	Street and number)		4b. City, To	own, or Location	on of Death		4c. County		
LAdiii	illei	NORTHWEST HOSPIT			RANI	DALLST	OWN		BALT	IMORE	
Funera Directo		5. Social Security Number 218-54-3640 6. Se	7. Age (In yrs.		If Under 1 'Months E	Year If Uno Days Hour	der 24 Hrs. rs Min.	8. Date of Birth Month, Pay 12/19/	1904	9. Birthplece (Sta Country)	nte or Foreign MD
p >		Usuel Residence of Decedent  10a. State 10b. County	10c Ci	ty, Town or Lo	cation					10d. Insid	e City Limits
aryla shov	5	,	/A		IMORE					100	Yes 2 □ No
the M	Director	10e. Street and Number	/ N	DALI	10f. Zip Ci	code			10g. Citizen of V	Λ	н
with with	ā	7218 PARK HEIGHT	S AVENUE			212	208			US	F
ours after death with the Marylan rai' or Itama 23a or 28a-f show	Funeral	11. Marital Status	12. Was Decedent Ever in U	J.S. 13.	Was Deceder	nt of Hispanic	Origin? (Sp	ecify Yes or No- Rican, etc.)	14. Raci	e - American India	٦,
or Ita	Ē	1 ☐ Never Married 2 ☐ Married	Armed Forces? 1 ☐ Yes 2 💢 No If Yes, Give		ir Yes, specity 1 ⊟ Yes 2 🕽			rican, etc.)	Specify	ck, White, etc.	ITE
ours Fig.	p		Year or Dates:								
If it is within 72 hours after death with the Maryland Hygiene.  Hygiene, with a hatural', or Itama 23a or 28a-f show inthe rhan "natural", or Itama 23a or 28a-f show int, the Medical Evantinal must be retified at	Completed	15. Decedent's Ed (Specify only highest grad	ucation de completed)	(Give	dent's Usual ( kind of work DO NOT use	done during n	nost of work	ing	16b. Kind of Bu	usiness/Industry	
within the same.	E GE	Elementary/Secondary (0-12)	College (1-4or 5+)	me.	DO 140 1 US6		MEMAKE	:R	OWN	HOME	
Hygir Hygir ant,	ပိ			<u> </u>		18. M	other's Nam	e (First, Middle,	Maiden Sumam	10)	
id be ental ked c	0	MANUATE LITER		WINK	LER	1	AUGUST	A		CZ	IMETH
s 1 and 2 should be filed within 72 hc  [Health and Mental Hygiene. Item 77 is marked othar than "natur other traumatic event, the Medical	-	19a. Informant's Name/Relationship (7	ype, Print)	19b. Maili	ng Address (S	Street and Nu	mber or Rur	al Route Numbe	r, City or Town,	State, Zip Code)	-
alth a		MAXINE MCKINNEY	/ DAUGHTER	48 E	. MONTO	GOMERY				MD 21230	
of He fitem		20a. Method of Disposition  XXBurial 2 ☐ Cremation 3-	Removal from State	Place of Dispo cemetery, crea	matory or other	er place)	1	Date		City or Town, Stat	е
Pages ment of I		*4 □Donation 5 □ Other (Specify	HEI	BREW F			<del></del>			MORE, MD	
permit. Pages 1 and 2 Department of Health a Important: If item 27 is	ouce.	21. Signature of Funeral Service Licen	960			Address of Fa	50			ROS., IN	
4054	OI _	23a. Pert1. Enter the disease, or comp	/ Mgi					ROAD -		LLE, MD 7	21208 imate
		shock, or heart failure. List only	one cause on each line.	un. Do not em	tel the mode	or dying, suci	i as cardiac	or respiratory ar	1031,	Interva	Between and Death
Physicia: /Medica		Immediate Cause (Final disease or condition resulting in death)	a. Due to (or as a conse								
Examine											
	e e	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	b. Due to (or as a conse	quence of):	23 111	4171	JECC	and			
outed d ansit	Examiner	Cause (Disease or injury that initiated events	C.	Ar	JEMIR	٦					
be exectician and burial-to	EX	resulting in death) Last	Due to (or as a conse	quence of):							
or ou, cate be executed bhysician and the burial-transit	lcal		d								
entific ding p	Physician/Med	IF FEMALE:	23c. If yes, outcome of pregn	ancy					224 Day	to of dollarons	
attenc for us	lan	23b. Was decedent pregnant in the past 12 months?	1 Live birth 2 Fet	aldeath 3[	☐Ectopic preg ☐ Other (spec					te of delivery inth Day	Year
the de	VSIC	1 ☐ Yes 2 🕅 No 9 ☐ Unknown	9 Unknown		_ co. (apos						
Inectorius, F.C. BOX 001000.  The law requires that the death certificate be executed are has been signed by the attending physician and page 2 should be detached for use as the burial-transit	by Pr		ontributing to death but not re-	sulting in the u	ınderlying cau	use given in P	art I.	23e. Did to	bacco use cont	ribute to the cause	of death?
w requires the bean signer should be								1 □ Y	es 2 No	3 Probably	Unknown
aw require s been si 2 should l	Completed							24a. Was autop	an 24b. \	Were autopsy find prior to completion	ngs available
The la	E							perfor	rmed?   0	death? 1 ☐ Yes 2 📉 No	
vital ician: sertifica ector, p	Be	25. Was case referred to medical				26. P	lace of Dea	h (Check only o	/ -		
Physician: r this certifica	P	1 ☐ Yes 2 No		ER/Outpatie			Nursing H	ome 5 Resid			
and and and and and and and and and and	00	27. Manner of Death 1 Natural 5 Pending	28a. Date of Injury (Month, Day Year)	28b. Time o		c. Injury at Work?		28d. Describe h	now injury occur	red	
Signature of the f	100	2 Accident investigation 3 Suicide 6 Could not be		nome farm st	M reet factory	1 Tes	2 🗆 140	28f Location /S	Street and Numb	per or Rural Route	Number.
or All after of Dirac	Certification:	4 ☐ Homicide determined	building, etc. (Spec		leet, lactory,	OTTICE		City or Tow	m, State)	01 01 110101	10777001,
To the Hospital or Attending within 24 hours after death.  To the Funaral Diractor: Attencompletely filled in by the fune			ysician: To the best of my kn	nowledge, dear	th occurred at	t the time, dat	e and place,	and due to the	cause(s) and ma	anner as stated.	
1 24 h	polical	(Check only 2 Medical Exer	niner: On the basis of examinand manner stated.	ation and/or ir	nvestigation, i	n my opinion,	death occur	red at the time,	date and place,	and due to the cau	se(s)
To th Within To th	Me		0010			License numb			29d. Date signe	d (Month, Day, Ye	,
1		Jaginda P 14	I ella m.o			2414			July 25	- In 20	i b .
6		30. Name and address of person who	completed cause of death (Ite	em 23a) (Type	Print) Jo	GINDE		WEHTIR			
9		MORTHWEST HES	17AL CENTER	15 N	MOM	US To	MM	MD.	21133		
200	State		32. Registrar's Sign	aluie	Acres 1	,					

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		1	For State Registrar	State	of Maryl		artment of Horificate of L		Re	eg. No.	06 23482
	siciar edica	1	Decedent's Name (First Middle, Middle)	Last)		M	edley		2. Date of Deat Month July	Day	3. Time of Death <b>Q005</b> AM
1	mine		a. Facility Name (If not institution,  Johns Hopkins			center	4b. City, Town, or Baltime		7	Baltime	
Fune Direct		5		3. Sex 1 □ M 2√□ F	7. Age (In )	yrs. last birthday, Yrs.	If Under 1 Year Months Days	If Under 24 Hrs. Hours Min.	8. Date of Birth (Month, Day,	Year)	Birthplace (State or Foreign Country)     Texas
ryland			Usual Residence of Decedent  10a. State  10b. County		10c	. City, Town or L	ocation				10d. Inside City Limits
h the Ma r 28a-f			Maryland B  Oe. Street and Number	altimore	9		10f. Zip Code		Dundalk	0g. Citizen of W	1 ☐ Yes 2123No /hat Country?
ath with	2	<u>g</u> _	68 Mavista Ave					21222			d States
036 urs after de al', or Iteme	10.00	2	11. Marital Status 1 □ Never Married 2 □ Marrie 3 ☑ Widowed 4 □ Divorced	Armed 1 Tyes	ecedent Ever Forces? s 2 M No Give r Dates:	in U.S. 13.	Was Decedent of Hi If Yes, specify Cubar 1 ☐ Yes 2 ☑ No	spanic Origin? (Spin, Mexican, Puerto Specify:	ecify Yes or No- Rican, etc.)		a - American Indian, k, White, etc. : : White
ire, Maryland 21215-0036 s. 1 and 2 should be filed within 72 hours after death with the Maryland if Health and Mental Hygiene. Item 27 is marked other than "natural", or Items 23s or 28s-f show other traumatic event, the Medical Exemilier from the notified	o de la companya de l	paladu	15. Decedent's (Specify only highest Elementary/Secondary (0-12)	grade complete	d) a (1-4or 5+)	(Give	dent's Usual Occupa a kind of work done o DO NOT use retired,	luring most of work	ing	16b. Kind of Bu	
ind 2. be filed v tal Hygie d other t	0	D C	12 Years 17. Father's Name (First, Middle, L	ast)		H	omemaker	18. Mother's Name			n Home e)
hould d Men	F	2	John Talbert  19a. Informant's Name/Relationshi	in (Type Print)		19h Mail	ing Address (Street a		ıra Head al Route Number	City or Town.	State. Zip Code)
Ma and 2 s alth an 27 te	1		Shawn Medley(Gr				1 Penhall				
Baltimore, bermit. Pages 1 at Department of Hea mportant: If item			20a. Method of Disposition 1 ☐ Burial 2 ☐ Cremation 4 ☐ Donation 5 ☐ Other (Sp		m State	•	osition (Name of matory or other place Service Co	9)			City or Town, State  Maryland
Baltimor permit. Pages Department of I	once.		21. Signature of Funeral Service L		,	D D	2. Name and Addres	s of Facility Funeral H	Iome of	Dundalk	, Inc.
		+	23a. Part1. Enter the disease, or o shock, or heart failure. List of	complications that	at caused the	death. Do not en	922 Wise A ter the mode of dying	Ave. Dun g, such as cardiac	dalk, Ma or respiratory arr	aryland est,	21222 Approximate Interval Between
Physici	_		Immediate Cause (Final disease or condition resulting in death)	a	Ische		rie				Onset and Death
/Medic Examin	_			Due	to (or as a cor Hyperc	holester	olemia				Years
760, C		Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	c	Hypert	ensignation of):					Years
<b>∞</b> 8 € =				d							
I Records, P.O. Box 6 The law requires that the death certifit ate has been signed by the attending same 2 should be detached for use as		Physician/Medical	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 M No 9 □ Unknown	1□Liv	outcome of pree birth 2 egnant at time known	Fetal death 3	□Ectopic pregnancy □ Other (specify)			23d. Dat Mor	e of delivery nth Day Year
rds, P.		2	Part II. Other significant condition	ns contributing to	o death but no	t resulting in the	underlying cause give	en in Part I.		bacco use contr es 2 No	nbute to the cause of death?  3 Probably 4 Unknown
		Сотріете							24a. Was a autops perform	med?	Were autopsy findings available prior to completion of cause of death?
of Vital F Physicien: Th this certificate		g R	25. Was case referred to medical examiner?	Hospital:			ont 30 DOA Othe	26. Place of Deat			
P P Sinis		tion: 10	1 Yes 2 No  27 Manner of Death  1 Natural 5 Pending 2 Accident investig	28a. Da	Inpatient ite of Injury Ionth, Day Yea	2 ER/Outpatie 28b. Time Injury	of 28c. Injun	4   Nuising ric	ome 5 Resid		
Division spltel or Attending ours after death. neral Director. After	en ko	Certification:	3 Suicide 6 Could n 4 Homicide determi	ot be 28e. Pla	ace of Injury - ilding, etc. (S		treet, factory, office		28f. Location (S City or Town	freet and Numb n, State)	er or Rural Route Number,
plte		edical C		xaminer: On the			th consumed at the tin nvestigation, in my o				arr as stated and due to the cause(s)
To the Hos within 24 hr To the Fun	dung	Ze.	29b. Signature and title of certifier	1111			29c. Licensi				1 (Month, Day, Year)
K			30. Name and address of person v	who completed c	ause of death	(Item 23a) (Type	p, Print)	ienija 1	Raltimora	MA	21224
Red	Stat		Jeffrey High 31. Date filed (Month, Day, Year) JUL 2 6	2006	Registrar's	Signature	RE astern Av	one (	Ser I I was 6	,	str Mr 1

			State of Maryland / Department of Health at Certificate of Death	and Men		ne No.200	6 23483								
	Dhusisi		1. Decedent's Name (First, Middle, Last)		Date of Death Month	Day Yo	3. Time of Death								
	Physicia /Medic		Lois Maulding	J	July 18	2006	2:28 P M								
	Examin		4a. Facility Name (If not institution, give street and number)  4b. City, Town, or Location of	of Death		4c. County of									
		Ш	Greater Baltimore Medical Center Towson	Od Heal a	10:11		imore								
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) 1 Under 1 Year 1 If Under 2 Hours 1 Days 1 Hours 1 Hou	Min.	Date of Birth Month, Day, Y	ear) 9.	Birthplace (State or Foreign Country)								
	Director		019-14-0227   1 M 2 K   88 Yrs.	Au	g 14, 1	.91/	New Hampshire								
	land ow		10a. State 10b. County 10c. City, Town or Location				10d. Inside City Limits								
	Man,	ţ	MD Baltimore				1√ Yes 2 No								
	death with the Maryland me 23a or 28a-f show rmust be rutified at	Director	10e. Street and Number 10f. Zip Code		10g	. Citizen of Wha	it Country?								
	h witi	alD	6225 York Road #N206 21212			U	SA								
	dea	ner	11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Original Report Original Report of Hispanic Original Report of Hispanic Original Report of H	gin? (Specify Puerto Rica	Yes or No-	14. Race -	American Indian, White, etc.								
9	or its	by Funeral	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 M No H Yes Give 1 ☐ Yes 2 M No Specify:		,	Specify:	white								
	within 72 hours after ene. then "neturet", or its he Medical Examine	d b	3 ☐ Widowed 4 N Divorced Year or Dates:		1-1										
- 1 ry	n 72 nat	Completed	15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of life. DO NOT use retired)	of working	unk 16	b. Kind of Busin	ess/Industry unk								
77	within	шc	Elementary/Secondary (0-12)  unk  College (1-4or 5+)  unk												
- p	Hygi ent.	Ö		r's Name (Fir	rst, Middle, Ma	iden Sumame)									
a L	lid be lental ked c	To Be	William Chester Ferguson	Zelma	Clook										
Mauding,	s 1 and 2 should be filed within 72 hours after death with the Marylar Health and Mental Hygiene. I Health and Mental Hygiene. Item 27 is marked other than "natural", or itame 23a or 28a-f show other traumatic event, the Medical Examinar must be notified at	_	19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number	r or Rural Ro	ute Number, C	ity or Town, Sta	te, Zip Code)								
<u>D</u> ≥	and 2 alth a i 27 i		Greater Baltimore Medical Ctr 6701 n. Charles Str	reet T	owson,	MD 2120	4								
ore	of He		20a. Method of Disposition  1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State	Date	20	c. Location - Cit	y or Town, State								
○ <u>m</u>	Pag ment ent: i		4 ⊠Donation 5 ☐ Other (Specify)												
Maulding, Lass Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours Department of Health and Mental Hygiene Importent: if Item 27 is marked other than "natural", eny injury or other traumatic event. Its Medical Exagnes.		21. Signature of Funeral Service Lio nsee  Ronald S. Wade, licector  Baltimore, MD 2	oard 6.	55 W. B	altimor	e Street								
			Zia, Part 1 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as complications that caused the death.				Approximate Interval Between								
	Physician		shock, o heart failure. List only one cause on each line.  Immediate Cause (Final	Λ.	· - 6		Onset and Death								
	/Medical		Immediate Cause (Final disease or condition resulting in death)  a.   (Uronic Obstructive Lunguage Due to (or as a consequence of):	19 101	10016		leav_s								
	Examiner		Sequentially list current to a												
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	be executed sicien and burial-transit	xarr	Cause (Disease or injury that initiated events c												
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387	the the	dic	d			-									
×	eath certific attending p for use as	√Me	IF FEMALE: 23b. Was decedent pregnant 23c. If yes, outcome of pregnancy			23d. Date o	f delivery								
ă	death s atte	iciai	in the past 12 months?  1   Ves   2   No			Month	Day Year								
o.	thet the de led by the a detached f	Physician/Med	9 ☐ Unknown												
رن م	Attending Physician: The law requires that the death certificate be executed death continued that this certificate has been signed by the attending physicien and by the funeral director, page 2 should be detached for use as the burial-transit	by P	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		23e. Did tobac	co use contribu	te to the cause of death?								
ğ	en sig	ed			1 🗆 Yes	2 □ No 3	Probably 4 Unknown								
၁	e law re hes be je 2 sho	pie		[	24a. Was an autopsy	24b. Wer	e autopsy findings available r to completion of cause of								
ĕ	ding Physician: The h. After this certificate he funeral director, page	Completed			performe	d? dea	th? Yes 22 No								
/ita	ician: Th certificete rector, pag	Be (	examiner/	of Death (Ch	neck only one)										
Ž	Physic this co	ဥ	1 Yes 2 No Hospital: 1 Inpatient 2 ER/Outpatient 3 DOA			e 6 Other (	Specify)								
Ę	ding P h. After t funera	on:	27. Manner of Death 1 ☑Natural 5 ☐ Pending 28a. Date of Injury 28b. Time of Injury 28c. Injury at Work?		Describe how	injury occurred									
<u></u>	Attendi death. ctor: A y the fu	cat	2 Accident investigation 3 Suicide 6 Could not be 288 Place of Injury. At home farm street factors effice.		28f. Location (Street and Number or Rural Route Number,										
Division of Vital Records, P.O. Box 6	or At after of Direct in by	Certification:	4 Homicide  determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)	281.1	City or Town, S	state)	or Hurai Houte Number,								
_	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the		29a. Certifier (Check only (Check only) (Che	d place, and o	due to the caus	se(s) and manne	er as stated.								
	the H thin 24 the F mplete	Medical	one) and manner stated.  29b. Signature and title of certifier 29c. License number				Month, Day, Year)								
	To To	_	Janon Blue MD 0006119	99		July 1	9. 2006								
			30. Name and address of person who completed cause of death (Item 23a) (Type, Print)			- / / (	. ( *								
_			Jason Black, 6565 North Charles ST. Suite	209,	Tous	on m	021204								
1	Sta Registr		30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  Tason Black, 6565 North Charks ST, Suik  31. Date filed (Month, Day, Year)  JUL 2 6 2006  32. Registrar's Signature												

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene

Months Dave Hours Min	Day Year				
JOSEPH ANTHONY M1 randa  July 20, 2  4a. Facility Name (if not institution, give street and number)  4b. City, Town, or Location of Death  Hampstead  Funeral  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year If Under 24Hrs.  Months Days Hours Min.	4c. County of Death				
4195 Saint Paul Road  Hampstead  Funeral  5. Social Security Number  6. Sex  7. Age (In yrs. last birthday)  If Under 1 Year   If Under 24Hrs.   8. Date of Birthday   Months   Days   Hours   Min   Months   Days   Hours   Min   Months   Days   Hours   Min   Months   Days   Hours   Min   Months   Days   Hours   Min   Months   Days   Hours   Min   Months   Days   Hours   Min   Months   Days   Hours   Min   Months   Days   Hours   Min   Months   Days   Hours   Min   Months   Days   Hours   Min   Months   Days   Hours   Min   Months   Days   Hours   Min   Months   Days   Hours   Min   Months   Days   Hours   Min   Months   Days   Hours   Min   Months   Days   Hours   Min   Min   Months   Days   Hours   Min   Min   Months   Days   Hours   Min   M	•				
Months Dave Hours Min	Carroll Baltimore				
Director 213 20 82/// VTI. OTE 10 Months Days Hours Min. A	rth(MM/DD/YYYY) 9. Birthplace (State or Foreign				
Director 213-29-8244   1 M 2 F   19 Yrs.   Will   Days   No. 10 Apr. 2	22, 1987 Country) MD				
Usual Residence of Decedent					
10a. State 10b. County 10c. City, Town or Location	10d. Inside City Limits				
Purp Republic Republi	1 Yes 2 No				
of the Wilson of	0g. Citizen of What Country? USA				
11. Marital Status 12. Was Decedent Ever in U.S. 13. Was Decedent of Hispanic Origin? (Specify Yes or No. 1) If Yes, specify Cuban, Mexican, Puerto Rican, etc.)	o- 14. Race - American Indian, Black, White, etc.				
The second of th	Specify: White				
15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Louid Occupation (Give kind of work done)  17	16b. Kind of Business/Industry				
To Dates:  15. Decedent's Education (Specify only highest grade completed)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Last)	Landananina				
9800-19   To provide the state of the state	Landscaping				
State   Stat	Maiden Surname)				
2 9 9 5 0 19a Informant's Name/Relationship (Type Print) 19h Mailing Address (Street and Number or Pural Pouto Number of Pural Pouto	mber City or Town State Zin Code)				
The proof of the p	, , , , , , , , , , , , , , , , , , ,				
PHES. CO. Mail 1979	20c. Location - City or Town, State				
Adrienne M. Miranda / mother 1543 Melton Road; Luthervil  Adrienne M. Miranda / mother 1543 Melton Road; Luthervil  Adrienne M. Miranda / mother 20a Method of Disposition  1	Timonium, MD				
Dulaney Valley Mem Gardens 7/25/06  Dulaney Valley Mem Gardens 7/25/06  21. Signature of Funeral Starv e Licentee  22. Name and Address of Facility  Dulaney Valley Mem Gardens 7/25/06	1050 York Road				
21. Signature of Funeral Stary e Licensee  22. Name and Address of Facility  Ruck Towson Funeral Home	Towson, MD 21204				
Physician  23a. Part I Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory and failure. List only one cause on each inc.	rest, shock, or heart Approximate Interval Between Onset and				
Twedical Immediate Cause (Final disease a Head and neck inujries	Death				
or condition resulting in death)  Due to (or as a consequence of):					
Sequentially list conditions, if any, leading to immediate Due to (or as a consequence of):					
cause. Enter Underlying Cause (Disease or injury that initiated					
Due to (or as a consequence of):					
UNPENDED  UNPEND					
UNPENDED  We will be the company of the strength of the company of	<b>1,08/10/11g9[8,dhb</b>				
O a series of the series of th	Month Day Year				
past 12 months?    Pregnant at time of death					
So yet a decedent pregnant in the past 12 months?  1 Live birth 2 Fetal death 3 Ectopic pregnancy 5 Other (Specify) 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23. Was decedent pregnant in the past 12 months? 1 Yes 2 No 9 Unknown 9 Unknown  Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.	obacco use contribute to the cause of death?				
O to the paper of	s 2 No 3 Probably 4 Unknown				
The law requires that the law requires the law requires that the law requires the law requir					
autory performance of the state					
The state of the s	2 No 1 Yes 2 No				
25. Was case referred to medical examiner?  1. Was a case referred to medical examiner?  1. Was a case referred to medical examiner?  1. Was a case referred to medical examiner?  1. Was a case referred to medical examiner?  1. Was a case referred to medical examiner?  1. Was a case referred to medical examiner?	Residence 6 V Other Scene				
Nursing Home 5 Property of Page 1 Property of Page 2 No Property of Page 2 No Property of Page 3 Property of	how injury occurred				
Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.    1	over by skid loader				
Investigation  Solve See Section 1  Solve See Section 1  Solve See Section 2  Solve See Section 3  Solve See See Section 3  Solve See Section 3  Solve See See Section 3  Solve See Section 3  Solve See Section 3  Solve See Section 3  Solve S	Street and Number or Rural Route Number, City				
or Town, S determined (Specify) Other Yard 4195 St. Pa	State) uI Road, Hampstead, MD				
8 É E > 29a Certifier					
29b. Signature and title of certifier 29c. License number	29d Date signed (Month, Day, Year)				
CaLille A O.C.M.E.	July 21, 2006				
30. Name and address of person who completed cause of death (Item 23a)  7 abjullab Ali, M.D. Assistant Modical Evaminar 111 Pape Street, Politimara MD 21201					
Zabiulian Ali, M.D. Assistant Medical Examiner 111 Perili Street, Baltimore, MD 21201					
State 31. Date filed (Month, Day, Year) 6 2006 32. Redistrar's Signature					

		•	State of Marylan  For State Registrar		artment of F		Reg.	2000	23485
÷ .	Physicia	an	Decedent's Name (First, Middle, Last)				Date of Death     Month	Day Year	3. Time of Death
*	/Medic	al	Frances Jean Mc Guire  4a. Facility Name (If not institution, give street and number)		4b. City, Town, o	Location of Do	JULY Z	4c. County of Dea	20:48 M
	Examin	er	6-000 SAMARITAN HOSLITAN		BALT	THORE	atti	N/A	MI 1
	Funeral		5. Social Security Number 6. Sex 7. Age (In yrs		If Under 1 Year Months Days	If Under 24 H		9. Bir	thplace (State or Foreign ountry) ryland
- 3	Director		217-16-1861 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				Aug. U, I	721 110	Tytanu
	yland		10a. State 10b. County 10c. C	ity, Town or Lo	ocation				10d. Inside City Limits
	e Ma	ctor	Maryland Baltimore	lomsou					1 ☐ Yes 2X No
	vith th	Dire	10e. Street and Number		10f. Zip Code 21 286		10g.	Citizen of What C	ountry?
	eath v	eral	800 Southerly Road #1414  11. Marital Status 12. Was Decedent Ever in N	US 13		ispanic Origin?	(Specify Yes or No-	14. Race - Am	erican Indian.
	r Item	Fun	Armed Forces?				(Specify Yes or No- erto Rican, etc.)	Black, Whi	
9	ral', o	l by	1 ☐ Never Married 2 ☐ Married 1 ☐ Yes 2 No If Yes, Give Year or Dates:		1 ☐ Yes 2 💢 No	Specify:		<sup>Specify:</sup> Шп	ite
S C	illed within 72 hours after death with the Maryland Hygiene. ther then "natural", or Iteme 23a or 28e-f show that the Medical Evaninal must be notified at	Completed by Funeral Director	15. Decedent's Education (Specify only highest grade completed)	(Give	dent's Usual Occup	durina most of w	yorking 16	b. Kind of Business	/Industry
121	within ane. then	ldm	Elementary/Secondary (0-12) College (1-4or 5+)		DO NOT use retired hier	7)	Mc	bil Oil	
Q 2	filed Hygie Dither I		17. Father's Name (First, Middle, Last)	000	HILLI	18. Mother's N	ame (First, Middle, Mai		
<u>a</u>	2 should be filed within 72 hours after death with the Marylan and Mental Hyglene. Is marked other than "natural", or iteme 23s or 28e-f show atmatic event, Ir.a Madical Examinal must be notified at	To Be	Raymond Lane			8eul	ah Hurl	Ley	
Maryland 21215-0036	permit. Pages 1 and 2 should be Department of Health and Menta Importent: If item 27 Is marked any injury or other treumatic so		19a. Informant's Name/Relationship (Type, Print)	100	•		Rural Route Number, C	-	
≥,	and tealth m 27 her tr		Charles McGuire / Husband		3		1414 Towsor	I,Md. 212 c. Location - City or	
Baltimore,	ages 1 or of H or ot		1 DiBunal 2 Ocemation 3 Delemoval from State		osition (Name of matory or other place				
	artmer artmer ortent injury		4 Donation 5 Other (Specify)  21. Signal of Fundal Arvice Linesee		In Cemeter 2. Name and Addre	-	.6/06 Ba	altimore, 1050 Yo	
Ba	Dep Impo		Val delati			•	al Home,Ind		
Ž.			23a. Part1. Enter the disease, of combinations that caused the dea shock, or heart aiture. Sonly one cause on each line.						Approximate Interval Between
	Physician		Immediate Cause (Final disease or condition	EPSI'C					Onset and Death
35	/Medical Examiner		resulting in death)  Due to (or as a conse	quence of):	7				
	Examile:	70	Sequentially list conditions, if any, leading to immediate b. Due to (or as a conse	equance of):					
	is W &	nlne	cause. Enter Underlying Cause (Disease or injury	querice or).					
<u>_</u>	n and	Examiner	that initiated events resulting in death) Last C. Due to (or as a conse	quence of):					
1760,	Attanding Physician: The law requires that the death certificate be executed refath.  sctor: After this certificate has been signed by the attending physician and sector. After this certificate has been signed by the attending physician and sector.	Ical	d						
89	artifica ing ph e as ti	Med	IF FEMALE:						
Box	eath certific attending p	lan/	23b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregration to the past 12 months?  4 Pregnant at time of	tal death 3	☐Ectopic pregnancy ☐ Other (specify)	,		23d. Date of de Month	livery Day Year
P.O.	ires that the de signed by the a I be detached f	Physician/Med	1 ☐ Yes 2 ☒No 4 ☐ Fregriant at time of 9 ☐ Unknown	death 30	Other (specify)	0= 1-3			
	s that ned b e deta	by Pt	Part II. Other significant conditions contributing to death but not re	sulting in the u	underlying cause giv	en in Part I.	23e. Did tobac	co use contribute t	o the cause of death?
rds	w require been sig should b	ed b	RENAL FAILUNG				1 ☐ Yes	2 □ No 3 □ P	robably 4 Munknown
Records,	has be	Completed	DIASTOLIC DYSTUA	VETER	1 OF TI	45 HOD	24a. Was an autopsy	prior to	utopsy findings available completion of cause of
<u>~</u>	Attanding Physician: The Isr death. ector: Atter this certificate haby the funeral director, page	Соп	PAROXYSMAL ATRIAL	FİR	RICATEC	m)	performed 1 ☐ Yes 2 🔀	d? death?	s 2 No
<u>≅</u>	ician: Th certificate rector, pag	Be	25. Was case referred to medical examiner?			26. Place of D	eath (Check only one)		
ō	Phys r this ral dii	-: To	27. Manner of Death 28a. Date of Injury	☐ ER/Outpatie			Home 5 Residence		ecify)
on	nding P Ith. :: After e funer	atlon	1 Matural 5 ☐ Pending (Month, Day Year) 2 ☐ Accident investigation	Injury		k? Yes 2∐No			
Division of Vital	ar dear dear dear dear dear dear dear de	Certification:	3 ☐ Suicide 6 ☐ Could not be determined 28e. Place of Injury - At building, etc. (Spec		reet, factory, office		28f. Location (Stree City or Town, S		tural Route Number,
ō	itel or rs afte et Dir led in	Ceri	Sunding, Sto. (epoc					,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	
	To the Hospitel or Attant within 24 hours after death To the Funerel Director: completely filled in by the	Medical	29a. Certifier  (Check only one)  Check only one)  Check only 2 Medical Examiner: On the basis of examiner and manner stated.	nowledge, deat nation and/or ir	th occurred at the tire timestigation, in my o	ne, date and pla pinion, death oc	ice, and due to the caus curred at the time, date	se(s) and manner a and place, and du	s stated. e to the cause(s)
	To the within Fo the complex	Me	29b. Signature and title of certifier		29c. Licens	e number	29d.	. Date signed (Mon	th, Day, Year)
			hlegenstere Mionel Ben	la MI	n les	000	T	14 21/	zan6
	$\setminus_{\Omega}$		30. Name and address of person who complyted cause of death ()ke	m 23a) (Type,	, Print)	T <sub>1</sub>			
	٧		ALEXANDE M. BENJO - 5601 LOLH A	AVEN BOD	VLEWARD, BA	timone,	NO 21239-	-Z995	
4	Sta Registi		31. Date filed (Month, Day, Year) 32. Segistrar's Sign	K A	nede				
	- 12 X		OOL NO						

FRANCES S. MC CURE

			T = For State Registrar	State of I	Marylan		artmen <i>rtificat</i>					giene	J 6	23485
	Physici /Medio		Decedent's Name (First, Middle, Last)     ZELDA				MAND	ELL			2. Date of Dea	3, Day 2006	Year	3. Time of Death 1:45 P M
	Examir		4a. Facility Name (If not institution, give s GENESIS SPA CREEK		er)		4b. City,		Location of			4c. County ANNE		
	Funeral Director		210 00 0700	7.	Age (In yrs.	last birthday) 8 Yrs	If Under Months	1 Year Days	If Under	24 Hrs. Min.	8. Date of Birt Month Day 01/23/	/ 1918	9. Birth Cou	nplace (State or Foreign untry) MD
	Aaryland I show	or	Usual Residence of Decedent  10a. State 10b. County  MD N/A		10c. Cit	y, Town or Lo								10d. Inside City Limits 1 X Yes 2 □ No
	with the N ta or 28e-	Direct	10e. Street and Number 3601 CLARKS LANE			DALLIZ	10f. Zip		21215	 5		10g. Citizen of	What Cou	untry? USA
36	within 72 hours after death with the Maryland ene. than "natural", or iteme 23a or 28e-1 show the Mudical Exerction must be routilled at	by Funeral Director		12. Was Decede Armed Force 1 Tyes 2 If Yes, Give Year or Date	s? X) No		Was Decect f Yes, spec	tent of His offy Cubar			city Yes or No- lican, etc.)	14. Rad Bla Specif	ck, White	ican Indian,
Maryland 21215-0036	ges 1 and 2 should be filed within 72 hours after death with the Marylar at of Health and Mental Hygiene. If Item 27 is marked other than "natural", or iteme 23a or 28e-1 show or other treumatic event, Item Marical Examiner man be redilled at	Completed	15. Decedent's Edu (Specify only highest grade Elementary/Secondary (0.12)	cation e completed) College (1-4d	or 5+)	16a. Deced (Give life. L	kind of wor DO NOT us	rk done d	urina mosi	t of workin	g	16b. Kind of B		
land	2 should be filed within and Mental Hygiene. Is marked other than eumatic event, the Ms	To Be C	17. Father's Name (First, Middle, Last) ABRAHAM			ROTKO	WITZ			ors Name	(First, Middle,	Maiden Suman	ne)	HURWITZ
, Mary	and 2 shou alth and N 27 Is ma er treums		19a. Informant's Name/Relationship ( <i>Ty</i> , ALAN FRIEDMAN / S									r, City or Town, POLIS,		
Baltimore,	permit. Pages 1 and Department of Heali Importent: If tem 2 any injury or other once.		20a. Method of Disposition 1 💢 Burial 2 □ Cremation 3 □ R 4 □ Donation 5 □ Other (Specify)	emoval from Sta	te C	Place of Dispo emetery, cren AREI T	natory or o	ther place		Da 7/2	te 5/2006	20c. Location WOODI		
Balti	permit. Departm Importe any inju		21. Signature Huneral Service Licence	nuge		22	. Name an	d Addres	s of Facilit	y SOL	LEVINS	ON & BF	-	INC. MD 21208
40	Physician /Medical		23a. Part1. Enter the disease, or complishock, or heart failure. List only or Immediate Cause (Final disease or condition resulting in death)	ACU	1 TE	REN					respiratory ar	rest,		Approximate Interval Between Onset and Death
8760,	eate be executed hysicien and the burial-transit the burial-transit	dical Examiner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Dy:	as a consequence of the conseque	uence of):	Den	NEN	TIA					3 WEERS YEARS
P.O. Box 68	ne death certific the attending p hed for use as	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 □ Yes 2 No 9 □ Unknown	3c. If yes, outcor 1 □ Live birth 4 □ Pregnant 9 □ Unknowr	2 Feta at time of d	Ideath 3	Ectopic pro Other (sp						te of deliventh	very Day Year
Ś	uires that the signed by the detaction	by	Part II. Other significant conditions con	tributing to deat	n but not res	ulting in the ur	nderlying ca	ause give	n in Part I.		23e. Did to	40		the cause of death?
al Recor		Completed									24a. Was a autop perfor	med?	prior to co death?	opsy findings available ompletion of cause of 2 \( \text{No} \)
Division of Vital Record	Attending Physician: Thir death.  •ctor: Atter this certificate by the funeral director, pag	ition: To Be	25. Was case referred to medical examiner?  1  Yes 2 No H  27. Manner of Death  1 Natural 5 Pending 2 Accident Investigation	ospital: 1  lnpa 28a. Date of li (Month, l		ER/Outpatien 28b. Time of Injury		8c. Injury Work	1 4 Nu	rsing Hom		ence 6 □Oth ow injury occur		fy)
Divisi	or Attendate after death Director:	Certification:	3 Suicide 6 Could not be determined	28e. Place of building,	Injury - At ho etc. (Specify	ome, farm, stre	eet, factory	, office		28	Bf. Location (S City or Tow	treet and Numb n, State)	er or Rui	al Route Number,
	To the Hospitel or Attenwithin 24 hours after deat To the Funerel Director: completely filled in by the	edical C	29a. Certifier 1 Certifying Physical Control only 2 Medical Examination	<b>1er</b> : On the basis	s of examina	tion and/or inv	estigation,	in my op	inion, deal	th occurre	at the time, o	late and place.	and due	to the cause(s)
-	To the within 2 To the complete	Me	29b. Signature and title of certifier	10-	· Ms	)	290	License	number	,	i	9d. Date signe	d (Month,	Day, Year)
(			30. Name and address of person who co	impleted cause of	of death (Item	1 23a) (Type,	Print)	00	11 36		1.	JULY	24	2006
	U Sta Registr	70.0	29b. Signature and title of certifier  30. Name and address of person who co  BiRIAN C. WAL  31. Date filed (Month, Day, Year)  JUL 2 6 2006	2. Regi	u), 40 strar's-Signa	OOS K	ار ان	RIDL	- KD	, 15/1	UTIMO	RE, MI,		136

			1 - For Amend Item Registrar	s State of Ma	ryland / I	Department SA In Certificate	of He or De	alth and 860,10/ eath	Mental Hy	giene . Reg. No.	0006	23487
	Physici	an	1. Decedent's Name (First, Middle, La	st)					2. Date of De Month	Day	Year	3. Time of Death
	/Medic		Nancy P. Niles						July .	18, 20	006	5;15 PM™
3	Examin	er	4a. Facility Name (If not institution, giv	e street and number)				ocation of Dea	th	4c. C	ounty of Deat	th
			Gilchrist	7 6	//a.um (ant hi		imor	e If Under 24 Hrs	Doto of Bio	1	0.8:-	Salara (Chaha as Fadaisa
	Funeral Director		210-32-0393	1 M 2 F 7. Age	(In yrs. last bi			Hours Min		v Year)	Co	hplace (State or Foreign cyland
	and		Usual Residence of Decedent  10a. State 10b. County		10c. City, Tow	n or Location						10d. Inside City Limits
	Manyi feho	ō	MD <del>Dorchest</del>	-0.26	Tay!	lor Island	4	<b>Baltim</b>	ore			1 ☐ Yes 2 ☑ No
	the 1	rect			rayı	10f. Zip 0				10g. Citize	on of What Co	ountry?
	3a or	Funeral Director	56 Oldustead Gr 300 Bayshore Dr	een Court		21210	0 - 21	669			USA	,
	death ms 2	era	11. Marital Status	12. Was Decedent E	ver in U.S.	13. Was Decede	nt of Hisp	anic Drigin? (	Specify Yes or No no Rican, etc.)	- 14	I. Race - Ame	
21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Maryland Department of Health and Mental Hygiene. Important: If Item 27 Is marked other then "natural", or Items 23a or 28a-1 ehow eny Injury or other traumatic event, the Medical Examiner must be notilled at once.	by Fur	1 ☐ Never Married 2 ☐ Married 3 ☒ Widowed 4 ☐ Divorced	Armed Forces? 1 ☐ Yes 2 ☒ N tf Yes, Give Year or Dates:	o	1 Yes 2		Mexican, Puei Specify:	rto Rican, etc.)		Black, Whit	e, etc. Thite
Ŏ	2 ho	ted	15. Decedent's E (Specify only highest gr	ducation	16a	Decedent's Usual	Dccupatio	on	unk	16b. Kind	d of Business/	Industry unk
21	thin 7	Completed by	Elementary/Secondary (0-12)	College (1-4or 5-	+)	(Give kind of work life. DD NOT use	retired)	ang most of we	nkiig			
	filed w Hygien other th	So		unk								
Maryland	uld be fi Nental H rked otl	Be	17. Father's Name (First, Middle, Last Edward Bernard				18		<sub>lme (First, Middle</sub> ra Hafer	Maiden S	umame)	
ž	should I	10	19a. Informant's Name/Relationship		101	n Mailing Address (	(Street and			or City or	Town State	Zin Code)
Ma	d 2 sl th an th an traur		Adam S. Kelley/s		boro Z	b. Mailing Address ( 1300 Raysh Five Tayl	nore	Road	MD 2166	n. City of t	i Owii, State, 2	пр Содву
	1 an Heall tem 2		20a. Method of Disposition	on soo bays	20b. Place of	of Disposition (Name	e of	stallu,	Date 2100		ation - City or	
Baltimore,	Pages tment of tant: If It jury or o		1 ☐ Burial 2 ☐ Cremation 3 ☐ 4 ☑ Donation 5 ☐ Other (Special Control of the Cont	(v)	cemete	ery, crematory or oth						
Ba	permit Depar Impor eny In		21. Signature of Euneral Service Lice ROPELO S	Wase State	gtor	State A: Baltimo			d 655 W. 01	Balt	imore	Street
			23a. Part Enter the disease, or com- shock, or heart failure. List only	plications that caused one cause on each lin	the death. Do	not enter the mode	of dying,	such as cardia	ic or respiratory a	rrest,		Approximate Interval Between
100	Physician		Immediate Cause (Finat disease or condition	LVN	7 Car	ncer						Onset and Death
	/Medical		resulting in death)	Due to (or as a	consequence	of):						
	Examiner		Sequentially list conditions,	b								
	De is	Examiner	if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a	a consequence	of):						
	and and I-tran	xan	that initiated events resulting in death) Last	c Due to (or as a	consequence	of):						
58760,	icate be executed physiclen and the burial-transit	a E			,	•						
587	licate phys s the	edical		_ d								
Box	certii nding use a		IF FEMALE: 23b. Was decedent pregnant	23c. tf yes, outcome		_				23	d. Date of det	iverv
ň	death a atte d for	Physician/M	in the past 12 months?	1□Live birth 4□Pregnant at		n 3 ⊟Ectopic pre- 5 ⊟ Other (spe-					Month	Day Year
P. O.	t the c by the ache	hys	9 Unknown	9□ Unknown								
œ.	es that the death certificate be executed igned by the attending physicien and be detached for use as the burial-transit	by P	Part II. Other significant conditions	contributing to death bu	t not resulting	in the underlying ca	use given i	in Part I.	23e. Did t	obacco use	contribute to	the cause of death?
Records,	w require been sig should b	edi							1/Å	Yes 2□	No 3□Pr	obably 4 Unknown
၁၁	e law re has be	Completed							24a. Was	an	24b. Were at	itopsy findings available completion of cause of
æ	The ate his page	mo.								rmed?	death?	
ita	ortifica ctor,	Be (	25. Was case referred to medical examiner?						ath (Check only	<del></del>		
× ×	hysic his ce Il dire	P	1 ☐ Yes 2 Ø No	Hospitat: 1 Inpatie	nt 2 ER/O			4   Nursing	Home 5 ☐ Resi	dence 6	Other (Spe	city) hospice
ū	ing P	on:	27. Manner of Death 1 Watural 5 ☐ Pending	28a. Date of Injur (Month, Day			c. Injury at Work?		28d. Describe	how injury	occurred	
Sio	death death stor: /	cat	2 Accident investigation 3 Suicide 6 Could not t		415	M		s 2 No	006 1	Ct		
Division of Vital	after of Direction by	Certification:	4 Homicide determined		iry - At nome, t :. (Specify)	arm, street, factory,	опісе		City or To	vn, State)	Number or Hi	ural Route Number,
	To the Hospital or Attending Physician: The law requires that the death certif within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use a	Medical C	29a. Certifier Gertifying Pi (Check only one)	hysician: To the best of miner: On the basis of and manner sta	examination at	e, death occurred a nd/or investigation, i	t the time, in my opini	date and plac	e, and due to the turred at the time,	cause(s) a date and p	nd manner as lace, and due	stated. to the cause(s)
	o the	Me	29b. Signature and title of certifier	1			License n			29d. Date	signed (Mont	h, Day, Year)
	- > + o		> Whan	Cum		D	583	303		11/4	, 19	2006
			30. Name and address of person who	completed cause of de	eath (Item,23a)	(Type, Print)	,		1	. /	-	-
			A 1	HARLURS, W	7 66	(Type, Print)	harb	e, St	BALDMON	in /	2120	7
	Sta		31. Date filed (Month, Day, Year)	32. Registra	r's Signature	R. W						
	Regist	ar	JUL 2 6	2006	182 B	Sparke						

06-05374 Lillian Ball North

Please Type or Print in Black Indelible Ink State of Maryland / Department of Health and Mental Hygiene 2006 23483

,		Registrar	Certi	ificate of	Death			Re	g. No.	100 -010
Physicia dical Exami	an/ ner	Decedent's Name (First, Middle,Last)     Lillian	В.	North			M Ju	ate of Deat Ionth IJy 23, 20	Day Year 006	2203 nrs
and the second	of the	4a. Facility Name (if not institution, give street and University Hospital-Shock Trauma	number)	4	b. City, Town, o Baltimore	or Location o	f Death		4c. County of	
Funeral		5. Social Security Number 6. Sex	7. Age (In yrs. las	st birthday)	If Under 1 Ye	ear If Under	r 24Hrs. 8.	Date of Birt		9. Birthplace (State or
Director		213-38-5518 1_M 2XF	84	Yrs.	Months Da	ays Hours	Min. S	Sept.2	8,1921	Foreign Country) Maryland
any		Usual Residence of Decedent  10a. State 10b. County	10c City T	own or Location	on					10d Inside City Limits
ž .	_	Maryland Baltimore		oenix						1 Yes 2 No
ith the Maryland 23a or 28a-f show notified at once.	Director	10e. Street and Number	1 110	CIIIX	10f. Zip Code			10	g Citizen of Wha	at Country?
h the N 13a or Lotifiec		15 Constantine Drive			211					S.A
ath with the items 23a st be noti	Funeral	1 Never Married 2 Married Armed	Decedent Ever in U.S. Forces?		Decedent of F es, specify Cub				14 Race - White,	- American Indian, Black, etc.
fter de l'', or i		3 Widowed 4 Divorced If Yes, Give or Dates:		1	Yes 2X	lo specify:			Specify:	White
5-0036 lled within 72 hours after Hygiene other than "natural", the Medical Examiner	ed by	15. Decedent's Education (Specify only highest g			's Usual Occup est of working li			done	16b. Kind of Bus	
36 vin 72   shan ", dical B	Completed	Elementary/Secondary (0-12) College	e (1-4 or 5+)	Public	: Healt	n Nurs	Δ .		Raltima	ore County
5-0036 led within 7 Hygiene lother than	S	17. Father's Name (First, Middle, Last)	·	1 45110	, near or			st, Middle, M	laiden Surname)	or e dodnoy
21215 uld be fil Mental F marked c event, t	a	John William	Ball	F 101 111		<u> </u>	Bess		Camper	
MD 21215-0036 d 2 should be filed within 72 hours after death with the Maryland th and Mental Hygiene n 27 is marked other than "natural", or items 23a or 28a-f she tumatic event, the Medical Examiner must be notified at once	٩	19a. Informant's Name/Relationship (Type, Print )  Patricia N. Bateman D	aughter		Address (Str N <b>stanti</b> 1					n, State, Zip Code)
		20a. Method of Disposition	20b. Pla	1	tion (Name of c		Dat			City or Town, State
MOF Pages nent of ant: H		1 X Burial 2 Cremation 3 Remova 4 Donation 5 Other Specify:	i i oni otate	dlawn C	emeter		7-28-2		Baltimo	ore, Maryland
Baltimore, permit. Pages 1 am Department of Heal Important: If iten injury or other tra		21. Signature of Funeral Service Licensee								al Home, Inc.
Physician		23a. Part I. Enter the disease, or complications that	t caused the death. [		.050 You e mode of dyin				Marylar est, shock, or hea	rt Approximate Interval
/Medical		failure. List only one cause of each line.  Immediate Cause (Final disease a. Multiple I	njuries							Between Onset and Death
Examiner		0.01	s a consequence of):							
	ř		s a consequence of):							
141	Examine	cause. Enter Underlying Cause (Disease of injury that initiated events resulting in death) Last  Due to (or a	s a consequence of)							
cuted and transit		d.								
ficate be executed g physician and equipment of the burial - transit	an/Medical	UNPENDED AMENDE								
876 tiffcate ng pliy as the l	M/us	COL INC. development to the	es, outcome of pregna e birth		al death 3	Ectopic	pregnancy		23d. Date of d Month	delivery Day Year
Box 6 he death cer the attendi	Physicia	4 Pre	egnant at time of deat known	th 5 Oth	er (Specify)				1	
O. B at the da lby the tached		Part II. Other significant conditions contribution		sulting in the ur	nderlying cause	given in Par	rt I.	23e. Did to	bacco use contrib	oute to the cause of death?
b, P.O. irres that the signed by 1	d by						_ 1	1 Yes	2 🗸 No 3	Probably 4 Unknown
ords, w requir as been s should	plete						[	24a. Was a	sy pr	Vere autopsy findings available for to completion of cause of
Rec The la licate h	Completed							perfor 1 Yes 2		eath? Yes 2 No
/ital sician: is certi lirector	o Be	25. Was case referred to medical examiner?	Inpatient 2 E	ER/Outpatient		Other	Check only of Nursing Ho		Residence 6	Other:
of \ ing Phy lightharpoonup of the control of the c	H-	M) (Mo	ate of Injury	28b. Time of In	njury 28c. In	jury at Work			ow injury occurre	ed .
sion ttendi death.	atio	2 Accident Investigation		1517 hrs		Yes 2	No			
Divis al or A s after al Direct	Certification:	Suicide 6 Could not be determined (Spec	lace of Injury - At hor fy) Major Road		t, factory, office	building, etc		or Town, St	tate)	r or Rural Route Number, City Road, Timonium, MD
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit		29a. Certifier 1 Certifying Physician: To the	best of my knowledge	e, death occurr	ed at the time,	date and pla	ce, and due	to the cause	e(s) and manner	as started
To the Howithin 24 P	Medical	one) 2 Medical Examiner: On the bas and manner	is of examination and er stated	d/or investigati			curred at the	time, date a	and place, and du	ue to the cause(s)
	Ž	29b Signature and title of certifier	200	2		nse number			July 24, 200	d (Month, Day, Year)
		30. Name and address of person who completed of	- TOLL	23a)	)   0.0	·	<u> </u>		July 27, 200	
20		Patricia Aronica-Pollak MD. Assi	stant Medical E	xaminer	111 Penn	Street, Ba	Itimore, M	<b>1</b> D 21201		
S Regis	tate trar	31. Date filed (Month, Day, Year) 32. JUL 2 6 2006	Registrar's Signatur	Local	ellas					
DHMH 17 Rev 1/2		2022		ORIGINAL						

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Physician Medical Examiner  To go and a control of death of the control of the co				23a. Part1. Enter the disease, or complica	ations that caused the death. D	o not enter the	mode of dying	g, such as card	ZOI liac or respirator	y arrest,			
Sequentially list conditions. If any, legating to immediate fair, legating to immediat	,	Physician		Immediate Cause (Final	Respira	tor	1 Fo	rilur	-e			Onset and Death	
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The state of the s		ed sit	ine	if any, leading to immediate cause. Enter Underlying									
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FFEMALE   23d. Date of delivery   23d. Date of liqury   23d. Date of liq	260	s be e sician	aiE										
25. Was case referred to medical examiner?  26. Place of Death (Check only one)  27. Manner of Death 1 Natural 5 Pending investigation 3 Suicide 4 Homicide 28a. Date of Injury At home, farm, street, factory, office 28b. Time of Injury At home, farm, street, factory, office 28c. Injury at Work? M 1 Yes 2 No  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, City or Town, State)  28d. Certifier (Check only one)  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Describe how injury occurred  28d. Location (Street and Number or Rural Route Number, City or Town, State)  29a. Certifier (Check only one)  29a. Certifier (Check only one)  29b. Signature and title of certifier, On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. Signature and title of certifier (Check only one)  30. Name and address of person who completed cause of death (Item 23a) (Type, Print)  29c. License number 29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)  29d. Date signed (Month, Day, Year)	9	g phy as the	edic	u									
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1	<u>ta</u>	ctor, p						26. Place of D			, 12,103	20110	
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Musing Mining Mining Market Ma		To the Mithin Fo the	Me	29b. Signature and title of certifier			29c. License	number		29d. Da	ite signed (Month,	Day, Year)	
State 31. Date filed (Month, Day, Year) 32. Registrar's Signature				Milion Karlan	wie. MD Pl	nusicia.	Ri	ES-1	000	Jur	ne 28	2006	
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State 31. Date filed (Month, Day, Year) 32. Registrar's Signature		40		1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		= Hopk	ins B	ryvion	Medic	Al Ce	viter		
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**ORIGINAL** 

DHMH 17 Rev 1/2001

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State of Maryland / Department of Health and Mental Hygiene

Daniel Eric Pems		- For State	e of Marylan		rtment of tificate of		and	Mental	Hygi		g No. 20	in c	2349
Physicia Medical Examin	n/	Registrar  1. Decedent's Name (First, Middle,L  DAN I		ERIC	<del></del> 17	PEMS	LFR			Date of Death Month uly 23, 20	h	3	Time of Death
Wedical Examin		4a. Facility Name (if not institution, o			1	4b. City, Tow		cation of De		uly 23, 20	4c. County of	Death	17451115
		Severn River	0- [7	A	-41245-4-	Severn	I	K11-1-0	Io	Data - (Did	Anne Aru		
Funeral Director		· ·	Sex 7.  X M 2 F	Age (In yrs. Ia 24	st birthday) Yrs	If Under 1 Months	Days	Hours		04/12/	h(MM/DD/YYYY) 1982	9. Birthp Foreign Count	EL
>	ļ	Usual Residence of Decedent  10a. State  10b. County		Idoa City	Town or Locati	1						11	0d. Inside City Limits
d e.			LINGTON		ARL I NG							- 1	X Yes 2 No
farylan 28a-f si at one	Director	10e. Street and Number				10f. Zip Co	ode			10	g. Citizen of Wha	t Country	n
h the N	힐	2779-A WASHING						22201					USA
death with the Maryland or items 23a or 28a-f show any must be notified at once.	Funeral	<ul> <li>11. Marital Status</li> <li>1 X Never Married 2 Marrie</li> </ul>		es?		s Decedent of es, specify C					14. Race - White,		n Indian, Black,
after de	by Fu		1 Yes ed If Yes, Give Year or Dates:	2 X No	1	Yes 2 X	No :	specify:			Specify:	WH	HITE
hours "natur		15. Decedent's Education (Specify Elementary/Secondary (0-12)	only highest grade of College (1-4		16a. Deceden during m	t's Usual Occost of workin				done	16b. Kind of Busi	ness/Ind	ustry
036 ithin 72 me. r than	Completed	2.0	Sellege (	4	SALES	REPR	ESEN	/ITATI	/E		COMP	UTEF	RS
	Be Co	17. Father's Name (First, Middle, La BARRY	st)	•	PEMSL	_ER	18.	Mother's N		st, Middle, M	laiden Surname)		CORY
D 212 should be and Ment 7 is mark		19a. Informant's Name/Relationship			19b. Mailing	Address (		nd Number	or Rura		ber, City or Town,		ip Code)
and 2 sealth a tem 27	1	BARRY PEMSLER 20a. Method of Disposition	-		lace of Dispos	ition (Name				E - MI	AMI, FL 20c. Location - C		
Baltimore, permit Pages I ar Department of Hee Important: If ite		1 Burial 2 Cremation 4 Donation 5 Other Special	• •		rematory or oth  NEBO		ERY		7/2	5/2006	KENDA	LL.	FL
Baltin permit Pr Departme Importan injury or	1	21. Signature of Funeral Service Lic		1	22. N	lame and Ad	dress of	Facility	S0	L LEVI	NSON & B	ROS.	, INC.
Physician		23a. Part I. Enter the disease, or col	mplications that caus	sed the death.	Do not enter the	3900 R	EIST lying, su	Ch as cardia	OWN ac or res	ROAD -	PIKESVI	LLE.	MD 21208 Approximate Interval
/Medical	- (9)	failure. List only one cause on											Between Onset and Death
Examiner		or condition resulting in death)	Due to (or as a co										
	ler	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a co	nsequence of	):								
-	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a co	onsequence of	):							+	
Division of Vital Records, P.O. Box 68760, To the Hospital or Attending Physician: The law requires that the death certificate be executed within 24 hours after death To the Finneral Director: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial - transit	edical E	UNPENDED	dAMENDED	<del></del>								$\dashv$	
60, ate be ex ohysician	Medi	IF FEMALE:	100 "	come of pregn	ancy						23d. Date of de	elivery	
Box 6876( re death certificate re the attending phy.	Physician/M	23b. Was decedent pregnant in the past 12 months?	1 Live birth	n t at time of dea	oth	tal death her <i>(Specify</i> ,		Ectopic pre	egnancy		Month	Day	Year
Box he death of the attented for us	hysi	1 Yes 2 No 9 Unkno	9Oriknowi		0.					-			
n of Vital Records, P.O. B ing Physician: The law requires that the d After this certificate has been signed by the funeral director, page 2 should be detached	≥	Part II. Other significant condition	s contributing to de	eath but not re	sulting in the u	ınderlying ca	iuse give	en in Part I.			bacco use contribu		e cause of death?
rds, require been si	Completed	, , , , , , , , , , , , , , , , , , ,							- 9	24a. Was a autops			esy findings available appletion of cause of
Reco The law cate has	фшо									perform 1 <b>V</b> Yes 2	med? dea	ath?  Yes	2 No
tal F cian: Certific	Be	25. Was case referred to medical examiner?	Hospital: 1 Inc				(O+	Death (Che					
of Vi	ے ا	1 Yes 2 No 27. Manner of Death			ER/Outpatient 28b. Time of I			at Work?	280	. Describe h	Residence 6 🗸		cene
itendin teath tor: Al	ation	1 Natural 5 Pending 2 Accident Investig		av Year) D6	1745 hrs	1	Yes	s 2 🗸 No	boa	ating accid	dent		
Division of Vital Records, To the Hospital or Attending Physician: The law requir within 24 hours after death To the Fineral Director: After this certificate has been s completely filled in by the funeral director, page 2 should	Certification:	3 Suicide 6 Could n	ot be 28e. Place of	of Injury - At ho	me, farm, stree	et, factory, of	fice buil	ding, etc.		or Town, St	ate)		Route Number, City
Hospita 24 hour Francra		4 Homicide	ician: To the best o		e, death occur	red at the tin	ne, date	and place,			r, Severn, MD e(s) and manner as		
To the within To the comple	Medical	one) 2 Medical Examin	ner: On the basis of e and manner stat		nd/or investigat				ed at the	time, date a			
	Σ	29b. Signature and title of certifier					icense r D.C.M.				29d. Date signed July 24, 2006		, Day, Year)
7	ı	30. Name and address of person wh	o ompleted cause	of death (Item	23a)						July 21, 2000		
10	10	Pamela Southall, MD	Assistant Medi	cal Examin	er 111 F	enn Stree	et, Bal	timore, N	MD 21:	201			
Sta Regist	ate rar	31 Date filed (Month, Day, Year)	2006 32. Regi	strar's Signatur	I A	and I							

Amend item# 28a, 28e, 28f, pen/E, 0858, 8/24/06 II

State of Maryland Department of Health and Mental Hygiene Office Registrar

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Please Type or Print in Black Indelible Ink. Ensure All Copies Are Legible. 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Month SELMA RUDO 155 AM 2006 /Medical 4a. Facility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner Hospital of Baltimurd Bultimore N/A Sinai If Under 1 Year If Under 24 Hrs. 8. Date of Birth Months Days Hours Min. (Mo2th, 134, 793)21 5. Social Security Number 7. Age (In yrs. last birthday) Birthplace (State or Foreign Country) **Funeral** 1 ☐ M 2 🐼 F 214-12-4192 84 MD Director Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location 17 le marked other then "neturel", or tiems 23a or 28a-1 ebow traumatic event, the Medical Explainar must be notified at traumatic event. 10d. Inside City Limits Directo BALTIMORE 1 ☐ Yes 2 ☑ No BALTIMORE 10e. Street and Number 10f. Zip Code 10g. Citizen of Wha! Country? 7 SLADE AVENUE #119 21208 USA by Funeral 12. Was Decedent Ever in U.S. Armed Forces? 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 11. Marilal Status 14. Race - American Indian Black, White, etc. 1 Never Married 2 Married 21215-0036 1□Yes 2M No WHITE 3 X Widowed 4 □ Divorced Completed 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 16b. Kind of Business/Industry Elementary/Secondary (0.12) filed withir Hygiene. College (1-4or 5+) HOMEMAKER OWN HOME Maryland 17. Father's Name (First, Middle, Last) 18. Mother's Name (First, Middle, Maiden Sumame) 2 should be f and Mental I permit. Pages 1 and 2 should be Department of Health and Mental Important: If Item 27 1e marked enty Injury or other traumatto ev 2012. HAROLD LEVIN SOPHIE PLOTKIN 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) CLIFFORD RUDO / SON 5 TROTTERS COURT - BALTIMORE, MD 21208, # 103 Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place) 20a. Method of Disposition 20c. Location - City or Town, Slate 1 Burial 2 Cremation 3 Removal from State BETH TFILOH CEMETERY | 07/04/2006 4 ☐ Donation 5 ☐ Other (Specify) WOODLAWN, MD 21. Signatur of Funeral Service Licen: 22. Name and Address of Facility SOL LEVINSON & BROS., INC. 8900 REISTERSTOWN ROAD - PIKESVILLE, MD 21208 Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, or hear) failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** Sub dural Large /Medical Due to (or as a consequence of): Examiner tead Transma econdury Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initialed events resulting in death) Last Due to (or as a consequence of): Examine Sit death certificate be executed burial-tran Due to (or as a consequence of) 3 | Ectopic pregnancy | RTIFICATION REPROVED BY MEDICAL EXAMINER physician Iclan/Medical as the attending for use as IF FEMALE: USB. 23c. If yes, outcome of pregnancy
1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 2 | Fetal death in the past 12 months? 1 ☐ Yes 2 No 4☐Pregnant at time of death Month Day Year signed by the a d be detached t o Phys 9 Unknown Records, P. Part II. Other significant conditions contributing to death bul not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? þ Diabetes Mellitus, hypertensson page 2 should Completed 1 🗌 Yes 2 X No 3 Probably 4 □Unknown ASA and Plavix A Mral Fibri llation, 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? Jas autopsy performed? Yes 217-No certificate therapy Division of Vital 1□ Yes director 25. Was case referred to medical 26. Place of Death Check only one Hospital: 1 VInpatient 2 ER/Outpatient 3 DOA Other: 4 Nursing Home 5 Residence 6 Other (Specify) 1 Yes 2 No 28a. Date of Injury

June 2006 y Year) this funeral 28b. Time of Injury 27. Manner of Death Certification: 28c. Injury al Work? 28d. Describe how injury occurred After or Attending 1 Natural 5 Pending death. 1 Yes 2 No 1197 2 Accident investigation UNKNOWY Subject the Director: 6 Could not be determined 3 Suicide 28e. Place of Injury - Al home, farm, street, factory, office building, etc. (Specify) Location (Street and Number of Rural Route Number City or Town, State) 7 Slade Ave., # 119 filled in by within 24 hours after To the Funeral Dire 4 Homicide WALKOWA Baltimore, MD Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. 29a. Certifier Medical completely (Check only one) 29b. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) D006277c Docori ress of person who completed cause of death (Item 23a) (Type, dim 2401 Belvedere Ave Baltimore 31. Date filed (Month. 32. Registrar's Signature State Registrar

Seima

	Physicia	an	1. Decedent's Name (First, Middle, Last)	State of Maryland (F			2. Date of Deat Month	th Day Year	3. Time of Death
and the second	/Medic		Rachel Louise Ramb				May	22 200	6 05:13A
7	Examin	er	4a. Facility Name (If not institution, give s		4b. City, Town, or Lo			4c. County of De	
	Funeral Director		5. Social Security Number 6. Sex 237-34-4614	7. Age (In yrs. last bin	thday) If Under 1 Year   I	Hours Min.	8. Date of Birth (Month, Day, Sept. 1	Year) (	irthplace (State or Forei
	2		Usual Residence of Decedent	10-0-7				-,	1.2
1	with the Maryland a or 28a-1 show Le notified at	-	10a. State 10b. County	10c. City, Town					10d. Inside City Limi
3	18a-1	ecto	MD Anne A	Arundel G1	en Burnie			0-00	
	With the state of	Ö			10f. Zip Code			Og. Citizen of What C	Country?
4	me 23	era	273 Glen Gary Gartl	1 2. Was Decedent Ever in U.S.	21061	anic Origin? (Spec		U.S.A.	nerican Indian.
Baltimore, Maryland 21215-0036	permit. Pages 1 and 2 should be filed within 72 hours after death with the Marylan Depertment of Health and Mental Hygiene. Depertment of Health and Mental Hygiene. Important: If them 27 is marked other then "natural", or Iteme 23a or 28a-1 show eny injury or other traumatic event, the Madical Examinar must be notified at once.	by Funeral Director	1 Never Married 2 Married 3 Avidowed 4 Divorced	Armed Forces? 1 ∐Yes 2t∏No If Yes, Give Year or Dates:	13. Was Decedent of Hisp If Yes, specify Cuban, 1 ☐ Yes 2 ☑ No		lican, etc.)	Black, Wh	
ŏ !	naturi	Completed	15. Decedent's Educ (Specify only highest grade		Decedent's Usual Occupation (Give kind of work done dur	on	2	16b. Kind of Busines	s/Industry
21	within viene.	npie	Elementary/Secondary (0-12)	College (1-4or 5+)	life. DO NOT use retired)	ing most or workin	9		
7	Hygien Hygien other th	Con		5+ Te	acher			Education	on
ם :	d oth	Be	17. Father's Name (First, Middle, Last)		18	3. Mother's Name		Maiden Surname)	
<u>×</u>	should nd Men marke umaric	스	Thomas E. Williams			Sallie			
a a	and raum		19a. Informant's Name/Relationship (Typ		. Mailing Address (Street and				
σ´ .	tealth		Mrs. Jean Hankey / 20a. Method of Disposition		03 Hillen Dri Disposition (Name of			.e <b>,</b> MD 2110 20c. Location - City o	
0	it of H		1 ⊠Burial 2 ☐ Cremation 3 ☐ Re	moval from State cemeter	y, crematory or other place)	May	25	·	
	then tent:		4 Donation 5 Other (Specify)		nd Veterans C	em 2006		Crownsvil	le, MD
Ba	Dependent Dependent Import eny injury once.		21. Signatu of al Service License  23a. Part1. Enter the disease, or complice	In mo1364	22. Name and Address of Second A	ve SW; G	len Bur	nie, MD 2	
E	Medical Examiner	Examiner	shock, or heart failure. List only on Immediate Cause (Final disease or condition resulting in death)  Sequentially list conditions, I any, learning to intra-odate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last	Due to (or as a consequence of Due to (or as a consequence)	of):		1. 1.	EXAMINER	Interval Between Onset and Death
P.O. Box 68760,	rne law requires that the death certificate be executed the has been signed by the effending physicien and bage 2 should be detached for use as the burial-transit	Physician/Medical E	IF FEMALE: 23b. Was decedent pregnant in the past 12 menths? 1 □ Yes 2 ☑ No 9 □ Unknown	c. If yes, outcome of pregnancy 1 □ Live birth 2 □ Fetal death 4 □ Pregnant at time of death 9 □ Unknown		OEMINO.	KION APPROVED B	23d. Date of d	
ds, г	w requires mai been signed t should be det	þ	Part II. Other significant conditions con	ributing to death but not resulting in	n the underlying cause given	in Part I.	23e. Did tob	. /	to the cause of death? Probably 4 Unkno
Division of Vital Records,	ine law rec ate has bee page 2 shou	Completed					24a. Was a autops perform	n 24b. Were a prior to death?	
a		0	25. Was case referred to medical		2	6. Place of Death			2010
>	rnysician: this certific al director.	To B	examiner?	ospital: 1 ☑Inpatient 2 ☐ ER/Ou	tpatient 3 DOA Other:	4 Nursing Hom	e 5 Reside	ence 6 Other (Sp	ecity)
0	fler		27. Manner of Death  1 SHatural 5 ☐ Pending	28a. Date of Injury (Month, Day Year) 28b. 1	njury <b>p</b> • 28c. Injury at Work?	2		ow injury occurred	
Sio	death. ctor: A y the fu	cati	2 Accident investigation	05/15/2006 Unk	CDOWN 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	s 💥 No	sub	ject fell	
Ž .	or Au efter d Direct in by	Certification;	3 Suicide 6 Could not be determined	28e. Place of Injury - At home, fa building, etc. (Specify)		2	City or Town	reet and Number or F n, State) n <b>Garv Car</b>	Rural Route Number, th, Glen Bu
_	To the Hospital of Attendi within 24 hours effer death. To the Funeral Director: A completely filled in by the fu	ledical C	29a. Certifier (Check only one)  1 Certifying Phys 2 Medical Examin	cian: To the best of my knowledge er: On the basis of examination and and manner stated.	, death occurred at the time.	date and place, a ion, death occurre	nd due to the ca	ause(s) and manner	as stated MD
	vithin To the comple	Me	29b. Signature and title of certifier	/ 0 0 0	29c. License n	umber		9d. Date signed (Mor	_
			Hall inter O	, hongemo 11	(Type, Print) imore Washing	07/22	8 1	May 22	2,2006

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			State of Maryland / Department of Health and Mental Hygiene  Certificate of Death  Reg. No.  State Department of Health and Mental Hygiene  Certificate of Death	5
	Physici /Medio	al	1. Decedent's Name (First, Middle, Last)  2. Date of Death  Month  Day  Year  2. Year  2. Date of Death  And The County of Death  Accounty of Death  4c. County of Death  4c. County of Death	1
1	Examin	er	Howard County General Hospital Columbia Howard	
	Funeral Director		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs. 8. Date of Birth (Month, Day, Year) 1 M 2 F 77 Yrs. Wonths Days Hours Min. Nov. 25, 1928  Usual Residence of Decedent	n
	daryland f ehow	ō	10a. State 10b. County 10c. City, Town or Location 10d. Inside City Limits  Maryland Baltimore Halethorpe 1□Yes ₩□No	
	r 28a-	Irect	10e. Street and Number 10f. Zip Code 10g. Citizen of What Country?	
	ath wit	raiD	1727 Hall Ave. 21227 USA	
980	be filed within 72 hours after death with the Maryland nta! Hygiene. In the man "natural", or iteme 23e or 28e-f ehow event, the Madical Examiner must be notified at	by Funeral Director	11. Marital Status  1	
Maryland 21215-0036	within 72 ho ene. than "natur he Medical	Completed	15. Decedent's Education (Specify only highest grade completed)  Elementary/Secondary (0-12)  College (1-4or 5+)  16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired)  16b. Kind of Business/Industry	
<u>م</u> 2	e filed Il Hygid Other	Be Co	8 Medical Doctor Health Care  17. Father's Name (First, Middle, Last)  18. Mother's Name (First, Middle, Maiden Sumame)	
ylar	should be nd Mental marked c		Elias Rudnikas Elena Katz	
Mar	id 2 sh th and th and traum		19a. Informant's Name/Relationship (Type, Print)  19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code)  Lorna D. Rudnikas- wife  1727 Hall Ave., Halethorpe, MD 21227	
	nit. Pages 1 and 2 should ertment of Health and Mer Grtant: If Item 27 is marke injury or other traumatic		20a. Method of Disposition 20b. Place of Disposition (Name of Computer Comp	-
Baltimore,	trnent of I		4 Donation 5 Other (Specify) Glen Haven Mem. PK. 7/25/2006 Glen Burnie, MD	
Bai	permit. Pag Deportment Important: Il any Injury o		21. Signature of Fineral Service Licensee  22. Name and Address of Facility Gary L. Kaufman Funeral Home at MMP, INC. 7250 Washington Blvd., Elkridge, MD 21075	i.
8760,	Physician and // Medical Examiner   the prival-transit	ical Examiner	23a. Part 1. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death disease or condition resulting in death)  Sequentially list conditions, if any, leading to immediate cause. Enter Undertying Cause (Disease or injury that initiated events resulting in death) Last  Approximate Interval Between Onset and Death death. Core of dying, such as cardiac or respiratory arrest,  Approximate Interval Between Onset and Death death death. Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):  Due to (or as a consequence of):	
P.O. Box 68	Physician: The law requires that the death certifical this certificete hes been signed by the attending phyral director, page 2 should be detached for use as the	Physician/Medi	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1	
rds, P	quires that in signed b uid be deta	þ	Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  23e. Did tobacco use contribute to the cause of death?  1 Yes 2 No 3 Probably 4 @Winknown	
I Records,	The law receive hes been page 2 sho	Completed	24a. Was an autopsy performed? performed? 1 Yes 2 No 1 Yes 2 No	,
<u> </u>	sician certifi irector	Be	25. Was case referred to medical examiner?  1   Yes   2   No   No   1   Minpatient   2   ER/Outpatient   3   DOA   Other: 4   Nursing Home   5   Residence   6   Other (Specific)	
Division of Vital	Jing After fune	ation: To	27. Mannar of Death 1	-
DIX	tai or Att rs after d ai Direct ed in by t	Certification:	3 Suicide 4 Homicide  Could not be determined  28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify)  28f. Location (Street and Number or Rural Route Number, City or Town, State)	
	To the Hospital or Attent within 24 hours after death To the Funeral Director: completely filled in by the	edical	29a. Certifier (Check only one)  11 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated.	
	To To To To To To To To To To To To To T	Σ	29b. Signature and title of pertifier  29d. Date signed (Month, Day, Year)	
	6		30. Name and address of person who completed use of death (Item 23a) (Type, Print)  KIN L GORING MD: 905 TAMES RIDGE RD; BOWIE; MD 20721	
T a	Sta Registra		31. Date filed (Month, Day, Year)  32. Redistrar's Signature  JUL 2 6 2006	

DHMH 17 Rev 1/2001

ORIGINAL

			For	State of Man		Departme	nt of I				e <sub>2 n n</sub>		031,95
			- State Registrar			Certifica	te of	Death		Reg. N	lo. U U	U	-0920
3	Physicia	_	1. Decedent's Name (First, Middle, Las Kathleen	t)		Rar	nson		2. Date of			ear XX	3. Time of Death 9 29 pM
	/Medic Examin		4a. Facility Name (If not institution, give	street and number)		4b. Cit	y, Town,	or Location of De	eath	1 4	c. County of		
1			Goog Sama	reitan H	TOSPIT	al T	Ba	Itimo	re		N A	A	
	Funeral Director		5. Social Security Number 6. Security 11 6. Security Number 11 6.	ex 7. Age (I ☐ M 2☐XF	In yrs. last bi	Yrs. If Und Month	er 1 Year s Days		lin. 8. Date of (Month,	Birth Day, Yea -18-1	937	Birthpla Countr	ce (State or Foreign y) Md.
	D .		Usual Residence of Decedent	1	On City Tou	vn or Location						10	d. Inside City Limits
	Marylar a-f ehov	tor	Md. 10b. County	1A "	oc. City, Tow	Baltimo	ore					100	1 XYes 2 No
	within 72 hours after death with the Maryland ene. then "naturel", or litems 23a or 28a-f ehow fra Mayleal Exp. illner rount be notified at	Funeral Director	10e. Street and Number 7198 McClean	Blvd.		10f. 2	ip Code 2123	34		10g. C	USA	at Countr	y?
	death	ner	11. Marital Status	12. Was Decedent Eve Armed Forces?	er in U.S.	13. Was Dec	edent of	Hispanic Origin?	(Specify Yes or Jerto Rican, etc.)	No-	14. Race -	Americar White, et	
980	urs after el', or Ite	by	1 ☐ Never Married 2 ☐ Married 3 ☑ Warried 4 ☐ Divorced	1 Yes 2 No If Yes, Give X Year or Dates:		1 Tes, s,			iono modin, etc.,		Specify:		ack
21215-0036	a within 72 hours jiene. r then "naturel", re Meulca Exe	Completed	15. Decedent's Ed (Specify only highest gra Elementary/Secondary (0-12)	lucation de completed) College (1-4or 5+)	16a	Decedent's Us (Give kind of v life. DO NOT	vork done	during most of	working	16b.	Kind of Busin	ness/Indu	stry
212	d with giene.	E				Teach	er's	Asst.			Sch	ool	
Maryland	should be filed within a Mental Hygiene. Thanked other then marked other the matic event, the Mental control of the Mental control o	To Be (	12th grade 17. Father's Name (First, Middle, Last) Eustace		Tho	ornton			Name (First, Mid Effie	ldle, Maide	en Sumame) <b>W</b> a	11	
ary		-	19a. Informant's Name/Relationship (7	ype, Print)	191	b. Mailing Addre	ss (Stree	t and Number or	Rural Route Nu	m <i>ber, Cit</i> y	or Town, St	ate, Zip C	Code)
	1 and 2 Health a tem 27 la		Patrick Ranson	Son	4	4107 Sil	nler	Oak Tr	ail, Owi	ngs	Mills,	Md.	21117
ore			20a. Method of Disposition 1		cemete	of Disposition (A ery, crematory o	r other pla	ice)	Date		Location - Ci		
Ĕ	nit. Pages artment of ortant: If it injury or o		4 Donation 5 Other (Specify	1)	Garri	son For	rest	Vet. /	'–19 <b>–</b> 06	C	wings	MITT	s, Md.
Baltimore,	permit. Pages Department of Important: If it eny injury or o		21. Signature of Funeral Service Licen	soo ware	$\supset$			ess of Facility .H. Eas			nore, M		21202 ve.
d			23a. Part1. Enter the disease, or comp shock, or heart failure. List only	y arrest,			Approximate nterval Between						
ů	Physician		Immediate Cause (Final disease or condition	Pancer	00+	ic C	an	cer					Onset and Death
	/Medical		resulting in death)	Due to (or as a c	-						-		, 0
	Examiner	_	Sequentially list conditions,	b		-0							
	ed sit	nine	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury	Due to (or as a o	consequence	or):							
, _	te be executed ysician and ie burial-transit	Examiner	that initiated events resulting in death) Last	cDue to (or as a c	consequence	of):							
760,	siciar buris	caiE		d									
89	ificate g phy as the												
Box	The law requires that the death certificate be executed to has been signed by the attending physician and age 2 should be detached for use as the burial-transit	Physician/Med	IF FEMALE: 23b. Was decedent pregnant in the past 12 months? 1 Yes 2 Mo	23c. If yes, outcome of 1 Live birth 2 [ 4 Pregnant at time 9 Unknown	Fetal death	h 3 Ectopic 5 Other		ey .			23d. Date of Month	,	y ay Year
P.0	that the de sed by the a detached f	Ph	Part II. Other significant conditions of	ontributing to death but	not resulting	in the underlying	cause q	ven in Part I.	23e. D	id tobacco	use contrib	ute to the	cause of death?
Records,	w requires that been signed should be dei	ted by							1	□Yes	2 □ No 3	☐ Probal	bly 4 □Unknown
ecc	has be	Completed								utopsy	pric	re autops or to com	y findings available oletion of cause of
<u> </u>	ıysiclan: The iis certificate ha director, page	Con								erformed?		th? Yes 2	□No
Vital	Physiclan: The this certificate ral director, pag	Be	25. Was case referred to medicat examiner?	11-2-1					Death (Check or	nly one)			
<b>→</b>	Physic this c	၉	Yes 2□No	Hospital:			DOA		g Home 5 F				
n C	Jing P	ion:	27. Manner of Death  Natural 5 ☐ Pending	28a. Date of Injury (Month, Day Y		Time of Injury M		ıryat ork? ]Yes 2 ☐ No	28d. Descri	be how in	ury occurred		
Division	or Attending fter death. Director: After in by the fune	Certification:	2 Accident investigation 3 Suicide 6 Could not be 4 Homicide determined		- At home, f (Specify)					n (Street a Town, Sta		or Rural i	Route Number,
u	To the Hospitel or Attending Ph within 24 hours after death. To the Funerel Director: After th completely filled in by the funeral	edicai Ce	29a. Certifier 1 Certifying Ph (Check only one) 2 Medical Exam	ysician: To the best of r niner: On the basis of ex and manner state	xamination a	je, death occurre nd/or investigati	ed at the t	ime, date and pl opinion, death o	ace, and due to	the cause ne, date a	(s) and mann	er as stated due to t	ted. he cause(s)
	thin 2 the mple	Med	29b. Signature and title of certifier	and manner state	u.	2	9c. Licen	se number		29d. E	ate signed (i	Month. D	ay, Year)
	2 ± ₹ 5			Suhan	70		Dr.	2571		-	1	76	7006
			30. Name and address of person who	completed cause of doc	th (Item 22a)	(Type Print)	シッ	0310			july	120	12000
	1			Baker U	(D)		San	naret	an Ho	Sort	عد	ı	
25	Sta		31. Date filed (Month, Day, Year)	32. Registrar's	s Signature		2.				_		

DHMH 17 Rev 1/2001

06-05272 Alise Radford

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1- For State Registrar			rtificate of			R	eg. No. 2 (	006 2349
Physicia Medical Examii		1. Decedent's Name (First, Midd Alise			Rad	dford		2. Date of Dea Month July 20, 2	Day Yea	3. Time of Death 1730 hrs
		4a. Facility Name (if not institution 1507 East Joppa Roa		)	4	b. City, Town, o	or Location of D	Death	4c. County of Baltimore	of Death e County
Funeral Director		5. Social Security Number 212–90–9917	6. Sex 7. And 1 M 2 X F	ge (In yrs. 44	last birthday) Yrs.	If Under 1 Ye	ear If Under 2 ays Hours	N. dies	3-1962	9. Birthplace (State or Foreign Country) Md.
w any		Usual Residence of Decedent  10a. State  10b. County		10c. City	, Town or Location	on				10d. Inside City Limits
daryland 28a-f show 1 at once.	Director	Md. Balt	imore		Towson	10f. Zip Code	-		0g. Citizen of Wh	1 X Yes 2 No
th the Maryland 23a or 28a-f she notified at once		1507 E. Joppa	Road Rm 1	06		212	86		US	*
5-0036 ed within 72 hours after death with the Maryland tygiene. other than "natural", or items 23a or 28a-f she the Medical Examiner must be notified at once	Funeral	11. Marital Status 1 Never Married 2 M 3 Widowed 4 Div	arried 12. Was Deceden Armed Forces 1 Yes 2 orced If Yes, Give Year		If Ye		an, Mexican, Pu	? ( Specify Yes or No uerto Rican, etc.)	- 14. Race White	- American Indian, Black, etc. Black
hours afi natural' Examine	ed by	15. Decedent's Education (Spe	or Dates: cify only highest grade cor		16a. Decedent		ation (Give kind		16b. Kind of Bus	
5-0036 ed within 72 hours af tygiene. other than "natural the Medical Examin	Completed	Elementary/Secondary (0-12)  12th grade		5+)		l Secre			   Kelly'	S
	Be Co	17. Father's Name (First, Middle, Luke	Last)	R	Radford			Name (First, Middle, Melmenia	Maiden Surname)	Holley
D 2121. should be fi and Mental B 7 is marked natic event,		19a. Informant's Name/Relations		_				r or Rural Route Nun		n, State, Zip Code)
	ł	Denise Radfor		20b.	P.O. Place of Disposit	tion (Name of c		rson, Md.	21285 20c. Location -	City or Town, State
Baltimore, permit Pages I ar Department of Hee Important: If ite injury or other tr		1 X Burial 2 Cremation 4 Donation 5 Other St	pecify:	aic	lt. Zion	Cem.		7-27-06	The second second	wne, Md.
Bal permi Depar Impo injur		21. Signature of Funeral Service	Warre	$\supset$	Ma	ame and Address	H. East	: 1101	timore, E. North	Ave.
Physician /Medical	10	23a. Part I. Enter the disease, or failure. List only one cause	on each line.				g, such as card	iac or respiratory arre	est, shock, or hea	Approximate Interval Between Onset and Death
Examiner		Immediate Cause (Final disease or condition resulting in death)	a. <u>(undri 1e)</u> Due to (or as a cons			ations				Beau
	iner	Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause	Due to (or as a cons	equence o	of):					
ed nsit	Examiner	(Disease or injury that initiated events resulting in death) Last	Due to (or as a cons	equence o	of):					
execut ian and ial - tra	Medical	<b>X</b> UNPENDED	d AMENDED ite	m#23a	,27,28a-f,	nerMF. o8'		 К +Т		
18760, tificate being physic as the bur		IF FEMALE: 23b. Was decedent pregnant in the past 12 months?	23c. If yes, outcome		nancy	al death 3			23d. Date of o	delivery  Day  Year
Box 687  te death certification the attending ted for use as t	Physician	1 Yes 2 No 9 ✓ Unk	4 Pregnant at	time of de	noth =	er (Specify)				
ires that the signed by the be detached	by Ph	Part II. Other significant condit	ions contributing to deat	h but not r	esulting in the ur	iderlying cause	given in Part I.			oute to the cause of death?
ords, I	leted								an   24b. W	Probably 4 Unknown  fere autopsy findings available
Recol	Completed							autop perfor 1 Yes		ior to completion of cause of eath?  Yes 2 No
Vital Reo ysician: The his certificate director, page	Be	25. Was case referred to medica examiner?	Hospital: 1 Inpatie	ent 2	ER/Outpatient		of Death (Ch		Residence 6	046
n of Vi Iing Physi After this funeral dir	n: To	1 Yes 2 No  27. Manner of Death  Natural 5 Peace	28a. Date of Inju (Month, Day,	1LA	28b. Time of In	ury 28c. Inju	ury at Work?	28d. Describe h	now injury occurre	-
Division of Vital Records, tal or Attending Physician: The law requir rs after death.  al Director: After this certificate has been sted in by the funeral director, page 2 should be	Certification:	2 X Accident Inves	stigation	ijury - At h	unk ome, farm, street		Yes 2 X No building, etc.	28f Location (S	approx. 1	years ago or Rural Route Number, City
Divis ospital or At hours after d uneral Direct y filled in by	- 1	4 Homicide deter	mined (Specify)	unk				or Town, Stunk		
Division of Vital Records, P.O. Box 68 within 24 hours after death.  To the Hospital or Attending Physician: The law requires that the death certiff within 24 hours after death.  To the Funeral Director: After this certificate has been signed by the attending completely filled in by the funeral director, page 2 should be detached for use as	Medical	(Check only one) 2 Medical Example 2	nysician: To the best of m miner: On the basis of exa and manner stated	y knowled mination a	ge, death occurre and/or investigation	ed at the time, o on, in my opinio	late and place, n, death occurr	and due to the cause red at the time, date a	e(s) and manner a and place, and du	as started e to the cause(s)
	Σ	29b. Signature and title of certifie	Jan M	1		29c Licen	se number	·	29d. Date signed July 21, 200	(Month, Day, Year)
	+	30. Name and address of person		,					, , = 30	
Sta	ate		Assistant Medical E			Street, Bal	timore, MD	21201		
Regist	rar	31. Date filed (Month, Day, Year)	2006 Blee	w.	J. Agai	We I				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death Reg. No 1. Decedent's Name (First, Middle, Last) 2. Date of Death 3. Time of Death **Physician** Day Year 2006 3:30 A<sup>M</sup> /Medical Robert Rothe July 19, 4a. Facility Name (If not institution, give street and number) Examiner 4b. City, Town, or Location of Death 4c. County of Death Future Care Irvington Knolls Ctr. Baltimore City N/A 5. Social Security Number 7. Age (In yrs. last birthday) If Under 1 Year If Under 24 Hrs.

Months Days Hours Min. **Funeral** 8. Date of Birth (Month, Dav. Year) Birthplace (State or Foreign Country) 1 €M 2 ☐ F Director 213-62-1835 52 Jan. 18,1954 Maryland Usual Residence of Decedent 10a. State 10b. County 10c. City, Town or Location ir than "natural", or items 23a or 28a-f show the Medical Examiner must be notified at 10d. Inside City Limits Director 1 Yes 2000 Dundalk Baltimore Maryland 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 21222 6836 Belclare Road death Completed by Funeral United States 12. Was Decedent Ever in U.S. Armed Forces? 11. Marital Status 13. Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian, Black, White, etc. Pages 1 and 2 should be filed within 72 hours after onent of Health and Mental Hygiene. Int: If Item 27 is marked other then "natural", or Iter 1 Yes 2 No
If Yes, Give
Year or Dates: 1 Never Married 2 Married Baltimore, Maryland 21215-0036 1 ☐ Yes 2 🛣 No Specify 3 ☐ Widowed 4 ☑ Divorced Specify. White 15. Decedent's Education (Specify only highest grade completed) 16a. Decedent's Usual Occupation 16b. Kind of Business/Industry (Give kind of work done during most of working life. DO NOT use retired) Elementary/Secondary (0-12) College (1-4or 5+) Facilities Contract Manager 4 Years Real Estate other traumatic event. 17. Father's Name (First, Middle, Last) Be 18. Mother's Name (First, Middle, Maiden Surname) ဂ္ Edward E. Rothe Ethel G. Griffith 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3113 Dunglow Road Dundalk, Maryland Mrs. Ethel G. Rothe (Mother) 20a. Method of Disposition 20b. Place of Disposition (Name of cemetery, crematory or other place) 20c. Location - City or Town, State 1 ☑Burial 2 ☐ Cremation 3 ☐ Removal from State 5 Department of Important: If eny injury or once. 4 □ Denation 5 □ Other (Specify) 7/21/2006 Oak Lawn Cemetery Baltimore, Maryland 21. Signature of Ameral Service Licensee 22. Name and Address of Facility
Duda-Ruck Funeral Home of Dundalk, Inc. Dundalk, Maryland 7922 Wise Ave. Part 1. Enter the disease, or complications that caused the eath. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** <u>Aspiration Pneumonitis</u> /Medical Due to (or as a consequence of) Examiner Anoxic Encephalopathy if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of) or Attending Physicien: The law requires that the death certificate be executed use as the burial-transit Traumatic Brain Injury physician and Division of Vital Records, P.O. Box 68760, CERTIFI Due to (or as a consequence of) Physician/Medical IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal de 23b. Was decedent pregnant 23d. Date of delivery 2 Fetal death 3 Ectopic pregnancy in the past 12 months? 1 ☐ Yes 2 ☐ No Month 4□Pregnant at time of death Day Year 5 Other (specify) 9 Unknown 9 Unknown signed by Part II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. by 23e. Did tobacco use contribute to the cause of death? Hypertension Completed 1 ☐ Yes 2 ☐ No 3 ☐ Probably 4 NUnknown Left Above Knee Amputation 24a. Was an 24b. Were autopsy findings available prior to completion of cause of death? autopsy performed? 1 Yes 1 ☐ Yes 2 ☐ No 24.3KNo After this certification, 25. Was case referred to medical examiner? Be 26. Place of Death Check only one Hospital: 1 | Inpatient | 2 | ER/Outpatient | 3 | DOA Other: 4∑ Nursing Home 5 ☐ Residence 6 ☐ Other (Specify) ဥ Yes 2 No Certification: 27. Manner of Death 28a. Date of Injury (Month, Day Year) 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 5 Pending investigation 1 Natural operator of motorcycle in collision 1 ☐ Yes 2 No death. 1 Director: A 2 Accident 1112005 17:057 3 🗌 Suicide 6 Could not be Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) Bayside Rd 2 13th 5+ Chasapala f 4 Homicide after Chesopeoke Beach Roadwan within 24 hours a \*\*X\*\*Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.

2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) 29a. Certifier Medical 29b. Sigfature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) PRIMARY CARE 2006 15 47 24 D0056948 30. Name and address of person who completed cause of death (Item 23a) (Type, Print) 300 Armory Place James Tansinda, M.D. Baltimore, Maryland 21201 Registrar's Signature State Registrar

06-05250 Danielle Russell

Please Type or Print in Black Indelible Ink
State of Maryland / Department of Health and Mental Hygiene

		1-For State Control of Certificate of Registrar Certificate of Cer			eg. No. 200	6 2349
Physicia Iedical Examir		Decedent's Name (First, Middle,Last)  PANTELLE MENTICES DIRECTLY		Date of Dea     Month	th Day Year	3. Time of Death
······································	ici	DANIELLE MELISSA RUSSELL  4a. Facility Name (if not institution, give street and number)	4b. City, Town, or Location of De	July 20, 2	4c. County of Deat	1251 hrs
Marin.		Good Samaritan Hospital	Baltimore	Cali	N/A	1
Funeral		5. Social Security Number 6. Sex 7. Age (In yrs. last birthday)	If Under 1 Year If Under 24	4Hrs. 8. Date of Bir	th(MM/DD/YYYY) 9. Bi	
Director		220-11-7276 1 M 2XF 20 Yrs		Min. 04/23	/1986 Foreign	gn <sup>puntry)</sup> MARYLAND
any		Usual Residence of Decedent  10a. State 10b. County 10c. City, Town or Locati				
* .		isos sity, romi or godan				10d Inside City Limits 1 X Yes 2 No
Aaryland 28a-f show 1 at once.	휭	MARYLAND         N/A         BALT           10e. Street and Number         BALT	I MORE 10f Zip Code		0g. Citizen of What Cou	
th the Maryland 23a or 28a-f sho notified at once.	Director	5315 LOTHIAN ROAD	21212	["	U.S.A.	nuyr
n with		11. Marital Status 12. Was Decedent Ever in U.S. 13. Was	s Decedent of Hispanic Origin?	( Specify Yes or No-		ican Indian, Black,
r death	Funeral	1 Yes 2 XNo	es, specify Cuban, Mexican, Pu	erto Rican, etc.)	White, etc.	
rs after rral",	۵		Yes 2 X No specify:		Specify: BLA	
2 hour	ompleted		's Usual Dccupation (Give kind ost of working life. DO NOT use	of work done retired)	16b. Kind of Business/	ndustry
5-0036 led within 72 hou Hygiene to other than "nat	힐	_l2yrs2yrsDIETA	78A		FOOD	
5-0 iled w Hygie Jothe the A	ပ၂	17. Father's Name (First, Middle, Last)		ame (First, Middle, N		
D 21215-00; should be filed within and Mental Hygiene, and Mental Hygiene, is marked other in natic event, the Med	o Be	ALAN AUGUSTUS RUSSELL  19a. Informant's Name/Relationship (Type, Print )  19b. Mailing		FORBES		
e, MD 21215-0036  I and 2 should be filed within 72 hours after death with the Maryland Health and Mental Hygiene. Fiten 27 is marked other than "natural", or items 23a or 28a-f she r traumatic event, the Medical Examiner must be notified at once	-		Address (Street and Number Lothian Rd., E			
e, M I and 2 Health item 2	1	20a. Method of Disposition 20b. Place of Disposi	tion (Name of cemetery,	Date	20c. Location - City or	
2 8 2 2 2		1 Xxurial 2 Cremation 3 Removal from State crematory or oth 4 Donation 5 Other Specify: ARBUTUS M		7 00 06		
Baltimo permit Page Department of Important: injury or ott	Ì		TEMORIAL   U / ame and Address of Facility LLIAM C BROWN C	7-28-06	BALTIMORE	, MARYLAND
E P B W		1120	)6 W NORTH AVEN	JUE .		ME P.A.
Physician /Medical		23a Part F. Entrolled dise to or complications that caused the death. Do not enter the fail to dist only one cause on each line.				Approximate Interval Between Onset and
Examiner	П	Immediate Cause (Final disease or condition resulting in death)  a. Cardiac Arrhythmia du  Due to (or as a consequence of):	<u>ie to Bi<b>ve</b>ntri</u> o	cular Hyp	ertrophy	Death
· · · · · · · · · · · · · · · · · · ·		Sequentially list conditions,  b				
	<u> </u>	if any, leading to immediate Due to (or as a consequence of): cause. Enter Underlying Cause				
	Examiner	(Disease or injury that initiated events resulting in death) Last Due to (or as a consequence of):				
and and rans		d				
760, Grate be executed sphysician and the burial - transi	Medical	XUNPENDED 23a,27 per we	g858 8-28-06 v	/t		
		IF FEMALE:  33b. Was decedent pregnant in the past 12 months?  23c. If yes, outcome of pregnancy  1  Live birth  2  ✓ Feta	al death 3 Ectopic pred	gnancy	23d. Date of delivery Month D	ay Year
Box 687 e death certifithe attending	Sici	1 Ves 2 No 9 Hokeaus 4 Pregnant at time of death 5 Oth	er (Specify)	<i>3</i>	Weiter	ay rea
the de ched f	Physician	Part II. Other significant conditions contributing to death but not resulting in the un	derbung cause given in Bort I	22a Did tak		
P.C	ò	S San San San San San San San San San Sa	denying cause given in Fait I,		pacco use contribute to t	
of Vital Records,  ng Physician: The law require  of this certificate has been similared director, page 2 should	Completed			24a. Was a		opsy findings available
e law te has				autops perform	ned? death?	ompletion of cause of
		25 Was case referred to medical	26.Place of Death (Chec	1 Yes 2	No 1 Yes	2 No
Division of Vital   Hospital or Attending Physician: 44 hours after death. Funeral Director: After this certificitely filled in by the funeral director.	e B B	examiner?  1 ✓ Yes 2 No  Hospital: 1 Inpatient 2 ✓ ER/Outpatient	Other		Residence 6 Other:	
ing Pl		27. Manner of Death  1 Natural 5 Pending  28a. Date of Injury (Month, Day, Year)  28b. Time of Injury (Month, Day, Year)		28d. Describe ho	ow injury occurred	
Sior Attend death death sctor:	ĕ	2 Accident Investigation	1 Yes 2 No			
Division pital or Attendii ours after death. teral Director: A	Certification:	3 Suicide 6 Could not be determined (Specify)	factory, office building, etc.	28f. Location (St or Town, Sta	reet and Number or Runate)	al Route Number, City
Hospit 4 hour 4 hour uners		4 Homicide	and at the time date and also	1		
Division To the Hospital or Attentwithin 24 hours after death To the Funeral Director: Completely filled in by the	Medical	Certifying Physician: To the best of my knowledge, death occurre (Check only one)  2 Medical Examiner: On the basis of examination and/or investigation and manner stated.	n, in my opinion, death occurred	ind due to the cause d at the time, date a	e(s) and manner as starte and place, and due to the	cause(s)
F 3 F 3	<b>≗</b>  ⁻	29b. Signature and title of certifier	29c. License number		29d. Date signed (Moni	h, Day, Year)
	1	1al 11102 1	O.C.M.E.		July 21, 2006	1
		30. Na he and address of person who completed dause of death (Item 23a)				
		Zabiullah Ali, M.D. Assistant Medical Examiner 111 Penn  31. Date filed (Month, Day, Year) 32 Begistrar's Signature	Street, Baltimore, MD 2	21201		
Sta Registra		JUL 0 6 2006	20			
Dinvin III Rev 1/200	+	ORIGINAL				

State of Maryland / Department of Health and Mental Hygiene 1 - For State Registrar Certificate of Death 1. Decedent's Name (First, Middle, Last) 2. Date of Death **Physician** ames /Medical Fecility Name (If not institution, give street and number) 4c. County of Death 4b. City, Town, or Location of Death Examiner 8. Date of Birth (Month Day, May 11, Birmplace (State or Foreign Country) **Funeral** 1 M 2□ F Days Hours unk 55 Director 215-56-6338 Usual Residence of Decedent with the Maryland 10a. State 10c. City, Town or Location ehow. 10d. Inside City Limits e 23a or 28e-f ehor MD 17 Yes 2 No Director Baltimore 10e. Street and Number 10f. Zip Code 10g. Citizen of What Country? 601 S. Charles Street 21202 USA Funeral 12. Was Decedent Ever in U.S. Armed Forces? or iteme unk Was Decedent of Hispanic Origin? (Specify Yes or No-If Yes, specify Cuban, Mexican, Puerto Rican, etc.) 14. Race - American Indian 11. Marital Status filed within 72 hours after 1 ☐ Yes 2 ☑ No If Yes, Give Year or Dates: 1 Never Married 2 Married Maryland 21215-0036 permit. Pages 1 and 2 should be filed within 72 hours a Department of Heelth and Mental Hygiene. Important: If Item 27 is marked other then "naturel", or eny Injury or other traumatic event, the Medical Exemple. 1 ☐ Yes 2X No Specify: white ģ Specify: 3 ☐ Widowed 4 ☐ Divorced Completed 16a. Decedent's Usual Occupation (Give kind of work done during most of working life. DO NOT use retired) 15. Decedent's Education (Specify only highest grade completed) unk unk 16b. Kind of Business/Industry College (1-4or 5+) Elementary/Secondary (0-12) unk unk 17. Father's Name (First, Middle, Last) unk 18. Mother's Name (First, Middle, Maiden Surname) 19a. Informant's Name/Relationship (Type, Print) 19b. Mailing Address (Street and Number or Rural Route Number, City or Town, State, Zip Code) 301 St. Paul Street Baltimore, MD Mercy Medical Center Baltimore, 20b. Place of Disposition (Name of cemetery, crematory or other place, 20a. Method of Disposition 20c. Location - City or Town, State 1 ☐ Burial 2 ☐ Cremation 3 ☐ Removal from State 4 ☐ Donation 5 X Other (Specify) in state 22. Name and Address of Facility
State Anatomy Board 655 W. Baltimore Street
Baltimore, MD 21201 21. Signature of Funeral Service Ronald Baltimore, MĎ un Part 1. Enter the disease, of complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, of neart failure. List only one cause on each line. Approximate Interval Between Onset and Death Immediate Cause (Final disease or condition resulting in death) **Physician** /Medical Examiner Sequentially list conditions, if any, leading to immediate cause. Enter Underlying Cause (Disease or injury that initiated events resulting in death) Last Physician/Medical Examiner Due to (or as a consequence of): physicien and s the burial-transit The law requires that the death certificate be executed Due to (or as a consequence of): Box 68760. use as IF FEMALE 23c. If yes, outcome of pregnancy 1 ☐ Live birth 2 ☐ Fetal dea 23b. Was decedent pregnant 23d. Date of delivery 3 Ectopic pregnancy 2 Fetal death ò in the past 12 months? 1 ☐ Yes 2 ☐ No Day Year 4 Pregnant at time of death 5 Other (specify) P.0. ed by the e 9□ Unknown Part II. Dther significant conditions contributing to death but not resulting in the underlying cause given in Part I. 23e. Did tobacco use contribute to the cause of death? δ Division of Vital Records, icate has been siç , page 2 should b 1 Yes 2 No 3 Probably 4 Unknown Completed 24b. Were autopsy findings available prior to completion of cause of death? 24a. Was an certificate has autopsy 1 ☐ Yes 2 2000 1 ☐ Yes Hospital or Attending Physician: funeral director, Be 25. Was case referred to medical 26. Place of Death (Check only one) examiner? Hospital: 1 Yes 2 0 t Impatient Other: 4 Nursing Home 5 Residence 6 Other (Specify) Certification: To 2 ER/Outpatient 3 DOA After this 27. Manner of Death 28b. Time of 28c. Injury at Work? 28d. Describe how injury occurred 1 Natural 5 Pending death. 1 ☐ Yes 2 ☐ No investigation М after death 2 Accident the 6 Could not be determined 3 Suicide 28e. Place of Injury - At home, farm, street, factory, office building, etc. (Specify) 28f. Location (Street and Number or Rural Route Number, City or Town, State) filled in by 4 Homicide within 24 hours a To the Funeral C 1 Certifying Physician: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.
2 Medical Examiner: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner stated. Medical 29a. Certifier (Check only To the 29h. Signature and title of certifier 29c. License number 29d. Date signed (Month, Day, Year) 31. Date filed (Month, Day, Year) 32 Registrar's Signature State Registrar